Office of Commissioner of Insurance and Safety Fire
Protect | Enforce | Educate | Inform

JOHN F. KING
Commissioner of Insurance and Safety Fire

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West Tower, Suite 702
Atlanta, Georgia 30334

**Surprise Billing Arbitration Application Form**

The Georgia Legislature enacted HB 888 to help protect consumers from surprise billing and payment disputes between insurers and out-of-network providers pursuant to the "Surprise Billing Consumer Protection Act". The new protections apply to all healthcare plans and state healthcare plans, with the exception of, limited benefit or plans listed under paragraph (3) of Code Section 33-1-2. HB 888 covers all bills for emergency and inadvertent (non-emergency) medical services received on or after January 1, 2020.

1. Who should file for Arbitration?
   - ✓ Arbitration is the dispute resolution process used for billing disputes between out-of-network providers or facilities and health plans
   - ✓ Parties involved:
     - Healthcare Provider/Facility
     - Health Plan
2. Review eligibility requirements. Or for more information visit:
   - ✓ Georgia Commissioner of Insurance and Fire Safety
3. Complete and sign this application
   - ✓ Applications that contain more than 4 enrollees will be rejected.
   - ✓ As will applications that merely attach spreadsheets of claim data.
4. Gather supporting documentation such as:
   - ✓ Copy of enrollee's health benefit plan
   - ✓ Copy of enrollee's health plan card
   - ✓ Claim form(s)
   - ✓ Initial Explanation of Benefits (EOB)/Explanation of Payment (EOP)
   - ✓ Additional EOBs/EOPs
   - ✓ Pertinent correspondences
   - ✓ Other supporting documentation

## General Information

1. Date of Arbitration Request:

2. Date written notice provided to the Health Plan:

3. Date of completion of 30-day negotiation period:
(Must be 30 days from the date in step 1)

4. The out-of-network claim is for:

- ◯ emergency medical service
- ◯ non-emergency medical service (inadvertent)

5. Health Plan Name:

6. For non-emergency medical service (inadvertent) only: Did the enrollee choose to receive non-emergency medical services from a non-participating provider?

- ◯ Yes
- ◯ No
- ◯ Unknown

7. Is there a history of network contracting between the Provider and Health Plan?

Select an Answer

## Provider/Facility Details

1. Provider's or Facility's Representative (First and Last Name):

2. Provider Specialty:

4. Provider's or Facility's Name:

3. Provider of Facility type:
(e.g., physician (MD)/(DO), laboratory, imaging/radiology)

Address:

| City: | State: | Zip Code: |
|---|---|---|
| | | |

| **Enrollee Details A** | | | |
|---|---|---|---|
| Full Name: | | | |
| Address: | City: | State: | Zip Code: |
| Enrollee's Plan ID#: | Enrollee's Group ID#: | | |
| Facility Name: | | | |
| Address: | City: | State: | Zip Code: |

| **Claim Information – Complete Claim Information for each claim** | | | | | |
|---|---|---|---|---|---|
| Claim #: | | | | | |
| Date claim submitted to Health Plan: | | | Date of Health Plan's Initial Allowance (paid claim): | | |
| Date of Service Start: | | | Date of Service End: | | |
| CPT Code with modifiers: | Provider's Billed Amount: | Provider's Final Offer Amount: | Health Plan's Initial Allowance: | Health Plan's Final Allowance/ Final Offer Amount: | Provider's usual billed charge for similar services for other out-of-network enrollees |
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| **Enrollee Details B** | | | |
|---|---|---|---|
| Full Name: | | | |
| Address: | City: | State: | Zip Code: |
| Enrollee's Plan ID#: | Enrollee's Group ID#: | | |
| Where were services rendered? | | | |
| Address: | City: | State: | Zip Code: |

| **Claim Information – Complete Claim Information for each claim** | | | | | |
|---|---|---|---|---|---|
| Claim #: | | | | | |
| Date claim submitted to Health Plan: | | | Date of Health Plan's Initial Allowance (paid claim): | | |
| Date of Service Start: | | | Date of Service End: | | |
| CPT Code with modifiers: | Provider's Billed Amount: | Provider's Final Offer Amount: | Health Plan's Initial Allowance: | Health Plan's Final Allowance/ Final Offer Amount: | Provider's usual billed charge for similar services for other out-of-network enrollees |
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| **Enrollee Details C** | | | |
|---|---|---|---|
| Full Name: | | | |
| Address: | City: | State: | Zip Code: |
| Enrollee's Plan ID#: | Enrollee's Group ID#: | | |
| Where were services rendered? | | | |
| Address: | City: | State: | Zip Code: |

| **Claim Information – Complete Claim Information for each claim** | | | | | |
|---|---|---|---|---|---|
| Claim #: | | | | | |
| Date claim submitted to Health Plan: | | | Date of Health Plan's Initial Allowance (paid claim): | | |
| Date of Service Start: | | | Date of Service End: | | |
| CPT Code with modifiers: | Provider's Billed Amount: | Provider's Final Offer Amount: | Health Plan's Initial Allowance: | Health Plan's Final Allowance/ Final Offer Amount: | Provider's usual billed charge for similar services for other out-of-network enrollees |
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| **Enrollee Details D** | | | |
|---|---|---|---|
| Full Name: | | | |
| Address | City | State | Zip Code |
| | | | |
| Enrollee's Plan ID#: | Enrollee's Group ID#: | | |
| Where were services rendered? | | | |
| Address | City | State | Zip Code |
| | | | |

| **Claim Information – Complete Claim Information for each claim** | | | | | |
|---|---|---|---|---|---|
| Claim #: | | | | | |
| Date claim submitted to Health Plan: | | | Date of Health Plan's Initial Allowance (paid claim): | | |
| Date of Service Start: | | | Date of Service End: | | |
| CPT Code with modifiers: | Provider's Billed Amount: | Provider's Final Offer Amount: | Health Plan's Initial Allowance: | Health Plan's Final Allowance/ Final Offer Amount: | Provider's usual billed charge for similar services for other out-of-network enrollees |
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| **Factors** |
| --- |
| (1) Describe the provider's level of training, education, and experience. (In the case of a hospital, the teaching status, scope of services, and case-mix) |
| (2) Provide an explanation of the circumstances and complexity of this particular case. |

(3) Describe individual patient characteristics.

(4) Enter the provider's usual charge for comparable services when the provider does not participate with the patient's health plan.

If you need to add more enrollees and/or claims, you may fill out another application form.

Applicant's Signature*: _____

Date: _____

*By signing this application, I attest that to the best of my knowledge, the information in this application is complete and accurate.