**Standard Notice and Consent Document Under the No Surprises Act - Based off of the CMS Model Form**

**(For use by nonparticipating providers and nonparticipating emergency facilities beginning January 1, 2022)**

 **Instructions**

Federal and State law balance billing laws prohibit out-of-network providers and facilities from balance billing insured individuals when providing services at an in-network facility. These laws allow such patients to give up their rights and consent to paying the higher out-of-network charges for certain services. Indiana law and the Section 2799B-2 of the federal Public Health Service Act (“PHSA”) specify the requirements for, and limitations of, seeking a patient’s consent under such circumstances. The Department of Health and Human Services (HHS) developed standard notice and consent documents that comply with the requirements of section 2799B-2(d) of the PHSA.

**When to Use the Consent Form**

A consent form is used providing items and services to participants, beneficiaries, enrollees, or covered individuals in group health plans or group or individual health insurance coverage, including Federal Employees Health Benefits (FEHB) plans by either:

* A nonparticipating provider or nonparticipating emergency facility when furnishing certain post-stabilization services, or
* A nonparticipating provider (or facility on behalf of the provider) when furnishing non- emergency services (other than ancillary services) at certain participating health care facilities.

A draft consent form, Attachment A, provides the form and manner of the notice and consent documents specified by the Secretary of HHS under 45 CFR 149.410 and 149.420, with modifications to align with Indiana law. HHS considers use of these documents in accordance with these instructions to be good faith compliance with the notice and consent requirements of section 2799B-2(d) of the PHS Act, provided that all other requirements are met. Indiana has not developed its own notice and consent documents.

**Administrative Requirements**

These documents may not be modified by providers or facilities, except as indicated in brackets or as may be necessary to reflect applicable state law. To use these documents properly, the nonparticipating provider or facility must:

* Fill in any blanks that appear in brackets with the appropriate information.
* Complete the notice and consent documents and delete the bracketed italicized text before presenting the documents to patients.
* Fill in the blanks in the “Estimate of what you may pay” section and the “More details about your estimate” section before presenting the documents to patients.
* Keep the standard notice and consent document physically separate and not attached to or incorporated into any other documents.
* Not keep the documents hidden or included among other forms.
* Ensure that a representative of the provider or facility is physically present or available by phone to explain the documents and estimates to the individual, and answer any questions, as necessary.
* Ensure that the documents meet applicable language access requirements, as specified in 45 CFR 149.420, including translating these documents or providing a qualified interpreter, as applicable, when necessary to meet those requirements.
* Provide the standard notice on paper, or, when feasible, electronically, if selected by the individual.
* Provide the individual with a copy of the signed consent document in-person, by mail or via email, as selected by the individua l.

 **Timing**

The notice and consent documents should be distributed according to the following timeframes:

* When an appointment for the items or services is made **at least 72** hours before the date that the items and services are to be furnished, these notice and consent documents must be provided to the individual (or representative) **at least 72 hours before** the date that the items and services are to be furnished.
* When an appointment for the items or services is made **within 72 hours** of the date the items and services are to be furnished, these notice and consent documents must be provided to the individual (or representative) **on the day the appointment is scheduled**.
* When the individual is provided the notice and consent documents on the day the items or services are to be furnished, including for post-stabilization services, the documents must be provided **no later than 3 hours** prior to furnishing the relevant items or services.

Note that Indiana law requires the consent to be given at least 5 business days before the health care services are scheduled to be provided.

**Nonwaivable Rights**

Out-of-network providers and facilities cannot ask patients waive their balance billing protections for the following items and services:

* Ancillary services, meaning:
	+ items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;
	+ items and services provided by assistant surgeons, hospitalists, and intensivists;
	+ diagnostic services, including radiology and laboratory services; and
	+ items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility.
* Items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the nonparticipating provider satisfied the notice and consent requirements.

**Follow-up Obligations**

The provider must give a copy of the signed written notice and consent to the participant, beneficiary, or enrollee in-person or through mail or email, as selected by the participant, beneficiary, or enrollee. If the actual charge for the scheduled health care services exceeds the estimate by the greater of: (i) one hundred dollars ($100); or (ii) five percent (5%); the provider must give the patient a written explanation why the charge exceeds the estimate.

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**Surprise Billing Protection Form**

**The purpose of this document is to let you know about your protections from unexpected medical bills. It also asks whether you would like to give up those protections and pay more for out-of-network care.**

**IMPORTANT: You are not required to sign this form and shouldn’t sign it if you did not have a choice of health care provider when you received care. You can choose to get care from a provider or facility in your health plan’s network, which may cost you less.**

**If you’d like assistance with this document, ask your provider or a patient advocate. Take a picture and/or keep a copy of this form for your records.**

You’re getting this notice because this provider or facility isn’t in your health plan’s network. This means the provider or facility doesn’t have an agreement with your plan.

**Getting care from this provider or facility could cost you more.**

If your plan covers the item or service you’re getting, federal law protects you from higher bills:

* When you get emergency care from out-of-network providers and facilities, or
* When an out-of-network provider treats you at an in-network hospital or ambulatory surgical center without your knowledge or consent.

Ask your health care provider or patient advocate if you need help knowing if these protections apply to you.

If you sign this form, you may pay more because:

* You are giving up certain legal protections against balance billing.
* You may owe the full costs billed for items and services received.
* Your health plan might not count any of the amount you pay towards your deductible and out- of-pocket limit. Contact your health plan for more information.

You **shouldn’t** sign this form if you **didn’t** have a choice of providers when receiving care. For example, if a doctor was assigned to you with no opportunity to make a change.

Before deciding whether to sign this form, you can contact your health plan to find an in-network provider or facility. If there isn’t one, your health plan might work out an agreement with this provider or facility, or another one.

See the next page for your out-of-network cost estimate.

# Estimate of what you could pay

**Patient name: Out-of-network provider(s) or facility name:**

**Total cost estimate of what you may be asked to pay:**

* [***Name of practitioner***] is an out of network practitioner providing ***[type of care]*** with ***[name of in network facility],*** which is an in-network provider facility within your health carrier's plan. ***[Name of practitioner]*** will not be allowed to bill you the difference between the price charged by the practitioner and the rate your health carrier will reimburse for the services during your care at ***[name of in network facility]*** unless you give your written consent to the charge.
* **Review your detailed estimate.** See Page 4 for a good faith estimate for each item or service you will receive.
* **Call your health plan.** Your plan may have better information about how much you will be asked to pay. You also can ask about what’s covered under your plan and your provider options.
* **Questions about this notice and estimate?** Call ***[Enter contact information for a representative of the provider or facility to explain the documents and estimates to the individual, and answer any questions, as necessary.]***
* **Questions about your rights?** Contact the Indiana Department of Insurance at https://www.in.gov./idoi or (317) 232-8582.

**Prior authorization or other care management limitations**

***[Enter either (1) specific information about prior authorization or other care management limitations that are or may be required by the individual’s health plan or coverage, and the implications of those limitations for the individual’s ability to receive coverage for those items or services, or (2) include the following general statement:***

***Except in an emergency, your health plan may require prior authorization (or other limitations) for certain items and services. This means you may need your plan’s approval that it will cover an item or service before you get them. If prior authorization is required, ask your health plan about what information is necessary to get coverage.]***

***[In the case where this notice is being provided for post-stabilization services by a nonparticipating provider within a participating emergency facility, include the language immediately below and enter a list of any participating providers at the facility that are able to furnish the items or services described in this notice]***

**Understanding your options**

You can also get the items or services described in this notice from these providers who are in-network with your health plan:

**More information about your rights and protections**

Visit [www.cms.gov/nosurprises](http://www.cms.gov/nosurprises) for more information about your rights under federal law.

# By signing this consent form, I give up my federal and state consumer protections and agree to pay more for out-of-network care.

With my signature, I agree to receive the items or services from (select all that apply):

* + ***[doctor’s or provider’s name] [If consent is for multiple doctors or providers, provide a separate check box for each doctor or provider]***
	+ ***[facility name]***

With my signature, I acknowledge that I am consenting of my own free will and am not being coerced or pressured. I also understand that:

* I am giving up some consumer billing protections under federal and state law.
* I may get a bill for the full charges for these items and services or have to pay out-of-network cost-sharing under my health plan.
* I was given a written notice on ***[enter date of notice]*** explaining that my provider or facility isn’t in my health plan’s network, the estimated cost of services, and what I may owe if I agree to be treated by this provider or facility.
* I received the notice either on paper or electronically, consistent with my choice.
* I fully and completely understand that some or all amounts I pay might not count toward my health plan’s deductible or out-of-pocket limit.
* I can end this agreement by notifying the provider or facility in writing before getting services.

**IMPORTANT:** You **don’t** have to sign this form. But if you don’t sign, this provider or facility might not treat you. You can choose to get care from a provider or facility in your health plan’s network.

 Or Patient’s signature Guardian/authorized representative’s signature

Print name of patient Print name of guardian/authorized representative

Date and time of signature Date and time of signature

**Take a picture and/or keep a copy of this form.**

**It contains important information about your rights and protections.**

# Details about your estimate

**Patient name: Out-of-network provider(s) or facility name:**

The amount below is only an estimate; it isn’t an offer or contract for services that binds you to be treated by this provider. This estimate shows the full estimated costs of the items or services listed. It doesn’t include any information about what your health plan may cover. This means that **the final cost of services may be different than this estimate**.

The estimate of our intended charge for ***[name or description of health care services]*** set forth in this statement is provided in good faith and is our best estimate of the amount we will charge. If our actual charge for ***[name or description of health care services]*** exceeds our estimate by the greater of: (i) one hundred dollars ($100); or (ii) five percent (5%); we will explain to you why the charge exceeds the estimate

**Contact your health plan to find out how much, if any, your plan will pay and how much you may have to pay.**

***[Enter the good faith estimated cost for the items and services that would be furnished by the listed provider or facility plus the cost of any items or services reasonably expected to be provided in conjunction with such items or services. Assume no coverage would be provided for any of the items and services.].***

**[*Populate the table below with each item and service, date of service, and estimated cost. Add additional rows if necessary. The total amount on page 2 must be equal to the total of each of the cost estimates included in the table.*]**

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| --- | --- | --- | --- |
| **Date of****service** | **Service code** | **Description** | **Estimated amount****to be billed** |
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| **Total estimate of what you may owe:** |  |

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