SURPRISE MEDICAL BILLING
REQUEST FOR BINDING ARBITRATION

Michigan Department of Insurance and Financial Services
Office of Research, Rules, and Appeals
DIFS-SurpriseBilling@michigan.gov
Fax: 517-763-0305

I. NON-PARTICIPATING PROVIDER INFORMATION

Name of Non-Participating Provider:	Point of Contact Name:
Address of Non-Participating Provider:	Point of Contact Phone:
Point of Contact Email:	Point of Contact Fax:

II. CARRIER INFORMATION

Failure to fill out this section completely may result in the rejection of your request.

Carrier:	Point of Contact Name:
Carrier Address:	Point of Contact Phone:
Point of Contact Email:	Point of Contact Fax:

III. INFORMATION TO BE INCLUDED

The following documents must be attached to the request. Failure to attach the documents to this request will result in a rejected request.

☐ Attach all documentation that was submitted to the carrier under MCL 333.24511(1):

- Clinical documentation demonstrating the complicating factor.
- The emergency patient's medical record for the health care service, with the portions of the record supporting the complicating factor highlighted.

☐ Attach the denial letter from the carrier.

IV. CERTIFICATION AND ACKNOWLEDGEMENTS

By signing this form, I understand and acknowledge that I will respond to the Department's inquiries regarding this request, and I certify that the information included on this form is correct and complete to the best of my knowledge and belief. I also understand and acknowledge that submitting false or misleading information is a cause for rejection of this request.

Authorized Signature:	Date:
Printed Name/Title:	