SURPRISE MEDICAL BILLING
REQUEST FOR REVIEW OF CALCULATION OF CHARGES

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

Instructions: This form may be submitted only if the request relates to one of the following circumstances. Please check which option applies to your request.

☐ I am a nonparticipating provider who provided a health care service to an emergency patient. The health care service was covered by the emergency patient's health benefit plan and was provided at either a participating health facility or a nonparticipating health facility.

☐ I am a nonparticipating provider who provided a health care service to a non-emergency patient. The health care service was covered by the non-emergency patient's health benefit plan and was provided at a participating health facility. The non-emergency patient either did not have the ability or opportunity to choose a participating provider, or was not provided the disclosure required by MCL 333.24509.

☐ I am a nonparticipating provider who provided a health care service to an emergency patient at a hospital that is a participating health facility, and the emergency patient was admitted to the hospital within 72 hours after receiving a health care service in the hospital's emergency room.

☐ I am a nonparticipating provider who provided a health care service to a non-emergency patient at a participating or non-participating health facility and did not provide the disclosure required by MCL 333.24509.

Please note: if the request relates to a health care service involving a complicating factor provided to an emergency patient, DO NOT complete this form. Instead, please complete FIS 2368. A "complicating factor" is a factor that is not normally incident to a health care service, including but not limited to: a) increased intensity, time, or technical difficult of the health care service; b) the severity of the patient's condition; or c) the physical or mental effort required in providing the health care service.

Please send this completed form and any attachment(s) to the above email address or fax number.

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

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

III. CLAIM INFORMATION

Please fill out the table below listing the date of service(s), ***each*** procedure performed you are requesting for calculation review, amount reimbursed by carrier for each procedure, and what you believe the carrier should reimburse. *Please attach a separate document if more space is needed.*

Date of Service	Procedure or Service Performed (must include CPT / HCPCS code)	Amount Reimbursed by Carrier	Amount Claimed

Please provide a brief rationale as to why the carrier should reimburse a different amount for the date(s) of service and procedure(s)/service(s) listed above. *Please attach a separate document if more space is needed.*

IV. INFORMATION REQUIRED

Please attach the following documentation with this request:

- Copy of claim form(s) submitted to carrier for procedure(s)/service(s) in question.
- Copy of any of the following:
    - explanation of benefit, explanation of review, or electronic fund transfer with amount paid by the carrier for the dates of service and procedure(s)/service(s) in question.

V. 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:	