SURPRISE MEDICAL BILLING ARBITRATOR
Application, Annual Attestation, and Change of Information

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

Instructions: In order to provide binding arbitration pursuant to MCL 333.24511 of the Public Health Code, 1978 PA 368, a person must submit this form to apply for inclusion on the Approved Arbitrators List. After initial approval, arbitrators must submit this form a) to notify the Department of Insurance and Financial Services (DIFS) of any change in information previously provided to DIFS and b) to make an annual attestation that information provided to DIFS remains complete and accurate. Send this completed form and attachment(s) to the above email address or fax number.

Please note: If you are approved for inclusion on Approved Arbitrators List, all information provided under Section I and Section III will be publicly available on the Approved Arbitrators List.

I. CONTACT INFORMATION

Name: Earlene R. Baggett-Hayes		
Address (Street): 110 North Perry Street		
City: Pontiac	State: Mi	Zip Code: 48342
Telephone Number: 248-949-9878	Email Address: erbhayes@sbcglobal.net	
Website (if applicable): baggetthayesadr.com	Firm or Company Name (if applicable): The Law and Mediation Center, PLLC	

II. APPROVAL INFORMATION

Check only one:

☒ I am applying for initial approval as an arbitrator and am not currently on the Approved Arbitrators List. This form must be submitted no later than 60 days prior to the date you wish to begin providing arbitration services. **Please complete only Section III below.**
☐ I am currently on the Approved Arbitrators List and am making an annual attestation that information provided to DIFS remains complete and accurate. This form must be submitted no later than 60 days prior to the date your initial approval renews. Please consult your approval letter to determine your renewal date. **Please do NOT complete Section III or IV below.**
☐ I am currently on the Approved Arbitrators List and am informing DIFS of a change in information or requesting removal from the Approved Arbitrators List. This form must be submitted within 30 days of the change. **Please complete only Section IV below.**

III. APPLICATION FOR INITIAL APPROVAL

In order to be included on the Approved Arbitrators List, you must be trained by the American Arbitration Association and/or the American Health Law Association. In addition, we request that you include information related to association memberships and experience so that this information can be included on the Approved Arbitrators List to assist parties in selecting an arbitrator.

(a) Check all that apply and attach documentation of your training:

☐ I am trained by the American Arbitration Association, and I have attached documentation of my training to this form.
☐ I am trained by the American Health Law Association, and I have attached documentation of my training to this form.

(b) List all active association memberships related to health care or alternative dispute resolution:

Financial Industry Regulatory Agency, Federal Mediation and Conciliation Service, Ford/Porsche Class Action Arbitration Program, National Mediation Board, Association for Conflict Resolution. I am a member of AARP.

(c) Provide a brief description of your experience related to health care, balance billing, and/or surprise billing alternative dispute resolution.

No experience except I have conducted arbitrations in the health care industry that typically involve employment/labor issues.

IV. CHANGE IN INFORMATION OR REQUEST FOR REMOVAL

☐ I am notifying DIFS of change(s) in the information from my most recent submission. Please describe the change(s) below:
☐ I am requesting that I be removed from the Approved Arbitrators List. Please provide the requested effective date of the removal:

V. SIGNATURE

By signing this form, I understand that I will respond to DIFS' inquiries regarding the contents of this form and any required document(s) that are attached. I certify that the information included on this form is correct and complete to the best of my knowledge.

I further understand that submitting false or misleading information may cause my application to be denied or my removal from the DIFS Approved Arbitrators List and may subject me to penalties as provided by law.

Signature:	Title:	Date:
	Arbitrator	6/2/21