



FROM



Request for Open Negotiation

Date of Notice: _____

You are receiving this notice because _____
Enter Name of Party Initiating Negotiations

a(n) _____

Enter one: Group health plan, health insurance issuer, Federal employee health benefits (FEHB) carrier, health care provider, health care facility, or provider of air ambulance services

is disputing the out-of-network rate for:

Insert appropriate descriptor of the item(s) or service(s)

The No Surprises Act provides a Federal independent dispute resolution (Federal IDR) process that group health plans, health insurance issuers of group and individual health insurance coverage, and FEHB carriers and out-of-network or nonparticipating health care providers, facilities, and providers of air ambulance services may utilize to determine the out-of-network rate for certain services following the end of an open negotiation period. The Federal IDR process is available only for certain services, such as out-of-network emergency services, certain services provided by out-of-network providers at an in-network facility, or air ambulance services. The Federal IDR process is also only available if a state All-Payer Model Agreement or specified state law does not apply.

What is an open negotiation period?

The open negotiation period is a period of up to 30 business days to determine an agreed-upon amount for the total out-of-network rate (including any cost sharing) for an item or service furnished by a nonparticipating provider, nonparticipating facility, or a nonparticipating provider of air ambulance services to a participant, beneficiary, or enrollee in a group health plan, group or individual health insurance policy, or FEHB carrier and for which a payment is required to be made by the plan or coverage.

What happens at the end of the open negotiation period?

If we have not agreed upon a payment amount by the end of the open negotiation on:

Enter 30 business days after the date of notice entered above

either of us may initiate the Federal IDR process by:

Enter date 4 business days after the end of the negotiation period

under which a certified IDR entity will select the payment amount for the item(s) and/or service(s) at issue.

Initiating the Federal IDR process does not prohibit us from agreeing on a payment amount after the open negotiation period has ended and before the certified IDR entity determines the payment amount.

For more information on the Federal IDR process and to obtain the notice to initiate the Federal IDR process, visit <https://www.nsa-idr.cms.gov>

PLEASE COMPLETE AND SIGN SUPPLEMENTAL FORM

Completed forms can be emailed to

AmbetterFederalIDRandOpenNegotiationRequests@centene.com

Or mailed to:

**Ambetter – NSA Request
PO Box 10407; Van Nuys, CA 91410**

By signature, I attest that I am authorized to submit this request and that the information on this form is accurate and complete to the best of my knowledge:

Signature

Date



Supplemental Open Negotiation Request Form

FOR NON-PARTICIPATING PROVIDERS TO INITIATE THE NEGOTIATION PROCESS UNDER THE NO SURPRISES ACT FOR INITIAL CLAIM PAYMENT

Non-participating providers may dispute the initial amount paid on a claim for emergency, air ambulance, or other professional services that are in scope for the No Surprises Act (NSA). To initiate the 30-day negotiation process provided under the NSA, complete and email to:

AmbetterFederalIDRandOpenNegotiationRequests@centene.com

Or by Mail:

Ambetter- NSA Requests at PO Box 10407, Van Nuys, CA 91410

The 30-day negotiation period starts when we receive a fully completed request form(s) and remit statement(s).

| | | |
|---|---|-----------------|
| Contact for Negotiation | Name | |
| | Facility, Group or Provider Representing | |
| | Phone | Email |
| Best Time of Day for Virtual Meeting | Option 1 | Option 2 |

| | | | |
|-----------------------------|---|--------------|------------|
| Provider Information | Name of Facility where Services Were Rendered: | | |
| | Place of Service Address | | |
| | City | State | Zip |
| | TIN# | NPI# | |

| Description of item(s) &/or Service(s) | Date Provided | Service Code (CPT, DRG or HCPCS) | Member Number | Ambetter Claim Number | Initial Payment Amount (if no initial payment was made, write N/A) | Amount Requested for Out of Network Rate (including any cost share) |
|--|---------------|----------------------------------|---------------|-----------------------|--|---|
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By signature, I attest that I am authorized to submit this request and that the information on this form is accurate and complete to the best of my knowledge:

| | |
|-----------|------|
| Signature | Date |
|-----------|------|