

NEW YORK STATE SURPRISE MEDICAL BILL CERTIFICATION FORM

You are protected from surprise medical bills. Your health plan must pay your health care provider, and your provider cannot bill you, except for any in-network cost-sharing.

- This form is required for surprise bills in (1) below for dates of service before 1/1/22 and for surprise bills in (2) below for all dates of service. This form is **NOT** required for surprise bills in (1) below for dates of service on and after 1/1/22 but helps identify when services are a surprise bill.
- Send a copy of this form to your **provider** and **health plan** (include a copy of any bill you received).
- Your provider may complete this form for a surprise bill described in (1) below for dates of service on and after 1/1/22, and your provider must send it to your **health plan**.

A surprise bill is when:

1. You're at an in-network hospital or ambulatory surgical facility and an in-network provider was not available; an out-of-network provider provided services without your knowledge; or you needed unforeseen medical services. Also, you did not choose to receive services from an out-of-network provider instead of from an available in-network provider before you went to the hospital or ambulatory surgical facility. (Emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services in an in-network hospital or ambulatory surgical facility are usually a surprise bill.)
2. During a visit with your in-network doctor an out-of-network provider treats you; your in-network doctor takes a specimen from you and sends it to an out-of-network lab or pathologist; or your in-network doctor refers you to an out-of-network provider (and referrals are required under your health plan). Also, you did not sign a written consent that you knew the services would be out-of-network and result in costs not covered by your health plan.

I certify to the best of my knowledge that (check one):

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I received services that are a surprise bill as described in (1) or (2) above and I want the provider to seek payment for this bill from my health plan (this is an "assignment") **OR**

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I am a **health care provider**, and the insured received services that are a surprise bill as described in (1) above for dates of service on and after 1/1/22.

Patient Name:		Date of Service:	
Patient Mailing Address:			
Insurer Name:			Insurance ID No:
Provider Name:		Provider Phone Number:	
Provider Mailing Address:			
Provider Contact Name (if different from provider name)			
Provider Contact Email Address:			
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation.			
Signature (of patient or provider):		Date signed:	

If you have questions about this form, contact the Department of Financial Services at (800) 342-3736.