New York State Out-of-Network Surprise Bill Law

The New York state "Surprise Bill" law will help you avoid surprise bills and unexpected expenses when receiving out-of-network care. Plus, it protects you in the case that you must go out-of-network for a specialist or procedure when they are not available within your plan's provider network. The Financial Services law section 603(h) defines a "surprise bill" as a bill for health care services, other than emergency services, received by:

- An in-network doctor was not available
- An out-of-network doctor provided the services without your knowledge
- Unforeseen medical circumstances arose at the time the health care services were provided

If you opted to seek services from an out-of-network provider when an in-network health plan provider is available, the bill does not fall under the surprise bill law.

Referrals: Your in-network doctor did not ask your consent to refer you to an out-of-network doctor, lab or other health care provider, and did not tell you it would result in costs not covered by your health plan.
An independent dispute resolution entity (IDRE) can determine if you need to pay the bill. You, the plan or your doctor may request an independent dispute resolution (IDR) for surprise bills and referrals. Use the attached form to submit your request. You do not have to pay the bill in order to be eligible to submit the dispute for review to an IDRE.

Dispute Resolution Process for Surprise Bills

1. **Submit your request for independent review.**
Contact your health plan customer service, at the phone number provided on your insurance card. Your health plan will help determine if the bill received qualifies as a surprise bill. If it qualifies, complete the attached form and your health plan will direct you on where to submit.
2. **An IDRE approved by the State of New York will screen your request for eligibility.**
If the IDRE needs more information they will contact the health plan or provider. If the requested information is not submitted within 3 business days, or if the application is not eligible, the IDRE will reject the application.
3. **The IDRE will send a letter to the person who initiated the request (you, the doctor or your health plan).**
The letter will include a request for information needed to complete the review, a request for any additional information that may be available to support your request, and where to send the information.
4. **You must submit any requested information within 5 business days of receiving the letter.**
If the IDRE receives a partial response or no response, the dispute will be decided based on the available information. No reconsideration will be allowed.
5. **The IDRE will make a determination within 30 days of receiving the request.**
If the IDRE feels either the provider's bill or the health plan's coverage policy is extreme it may direct them to attempt a good faith negotiation for settlement. They will have up to 10 business days for this negotiation. The IDRE will forward copies of the decision to the health plan, provider and other applicable parties within 2 business days of the decision.