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Maine Independent Dispute Resolution – Eligible Patient Application

Maine law allows for independent dispute resolution of a surprise bill for emergency services or a bill for covered emergency services rendered by an out-of-network medical service provider. The law's protections apply to bills for emergency medical services received on or after October 1, 2020. For more details, see Maine 2019 Public Law, Chapter 668 (An Act to Protect Consumers from Surprise Emergency Bills).

Who may submit an application for Independent Dispute Resolution (IDR)?

- Uninsured patient; or
- A person covered under a self-insured/ERISA plan

Application Process

1. Complete and sign this application to the best of your ability.
2. Gather supporting documentation, such as:
   - ✓ Copy of bill
   - ✓ Claim form(s)
   - ✓ Pertinent correspondence
   - ✓ Other supporting documentation (e.g., copies of emails, negotiation attempts)
3. Securely send this completed application and supporting documentation to Maximus, either:

   1. By secure E-mail at: MEdisputes@maximus.com
   2. By fax at: (585) 425-5296
   3. By mail at: Maximus
      Attn: ME IDR
      3750 Monroe Avenue, Suite 705
      Pittsford, NY 14534

General Information

1. Date IDR application submitted:

2. Party submitting IDR application:
   - ☐ Uninsured Patient
   - ☐ A person covered under a self-insured plan. Please state the name of the plan:

3. The bill is:
   - ☐ A surprise bill for emergency services
   - ☐ A bill totaling $750 or more received by an uninsured person for emergency health services

Patient Details

Patient's First and Last Name:

Address	City	State	Zip Code

E-mail:	Telephone No.:

Location where services were rendered (e.g., hospital, free-standing ER)

Name of Facility:

Address	City	State	Zip Code

Provider #1 Details			
Provider's First and Last Name:			
Provider's Specialty:	Telephone No.:		
Address	City	State	Zip Code
Claim Information – Complete claim information for each claim			
Date(s) of Service:			
Provider/Facility's charge (amount in dispute; attach copy of bill):	Patient's payment offer:		

Provider #2 Details			
Provider's First and Last Name:			
Provider's Specialty:	Telephone No.:		
Address	City	State	Zip Code
Claim Information – Complete claim information for each claim			
Date(s) of Service:			
Provider/Facility's charge (amount in dispute; attach copy of bill):	Patient's payment offer:		

Provider #3 Details			
Provider's First and Last Name:			
Provider's Specialty:	Telephone No.:		
Address	City	State	Zip Code
Claim Information – Complete claim information for each claim			
Date(s) of Service:			
Provider/Facility's charge (amount in dispute; attach copy of bill):	Patient's payment offer:		

Provider #4 Details			
Provider's First and Last Name:			
Provider's Specialty:	Telephone No.:		
Address	City	State	Zip Code
Claim Information – Complete claim information for each claim			
Date(s) of Service:			
Provider/Facility's charge (amount in dispute; attach copy of bill):	Patient's payment offer:		

If you need to add more providers and/or claims, you may fill out another application form.

Applicant's Signature*: _____

Date: _____

*By signing this application, I attest that to the best of my knowledge, the information in this application is true and accurate. Applicant agrees to be bound by the outcome of the IDR, to submit to the jurisdiction of the Superintendent and the courts of the State of Maine.