



NOTICE OF OPEN NEGOTIATION PERIOD

PG:
Log#:

This form and accompanying documentation **must be submitted within 30 days from the date on the Explanation of Payment (EOP)**. Retain a copy for your records. **Submit only one member per Notice of Open Negotiation Period form.**

Provider name: _____ Date prepared: _____
 Tax ID: _____ Person completing form: _____
 Provider NPI #: _____ Telephone: _____

Member name: _____ Claim #: _____ DOS: _____
 Member Health Plan ID#: _____ Patient account #: _____ DOB: _____

<p>Services Covered Under the No Surprises Act (choose one): Emergency Services Non-Emergency Services from out-of-network providers at in-network facilities Services from out-of-network air ambulance service providers</p> <p>Expected reimbursement for services amount in dollars :</p>	<p>Applicable NSA Plans (choose one): HMO PPO TPA</p>
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Provider comments:

Fax to: **570-214-1656**

Mail to:
ATTN: No Surprises Act
Geisinger Health Plan
PO Box 160
Glen Burnie, MD 21060

HEALTH PLAN USE ONLY
Approved
Denied (reason):