# FOUR SEASONS DERMATOLOGY VERMONT

# PATIENT-PROVIDER DISPUTE RESOLUTION FORM

| | Yes/No |
|---|---|
| Did you receive a Good Faith Estimate from the billing department? | |
| Is the bill you received at least $400 more than the Good Faith Estimate? | |
| Is the date on the statement within the last 120 calendar days? | |

*If you answered NO to any of these questions, you do not qualify for dispute resolution. If you answered YES to all questions, you may continue with the rest of the form.*

Patient Name: _____

Name of person disputing, if different from above:

_____

Mailing Address: _____

_____

Phone Number: _____

| | |
|---|---|
| Date of Service | |
| Good Faith Estimate Amount | $ |
| Actual Billed Charges | $ |

You may email this form to billing@skinvt.com or mail to 354 Mountain View Dr., Suite 300, Colchester VT 05446. If you need assistance, call 802-864-0192.

You may also start a dispute with the U.S. Department of Health and Human Services (HHS). Their dispute form can be found at cms.gov/nosurprises. They can be reached by phone at 1-877-696-6775. Please note they require a $25 fee to use their dispute process.