



HEALTH & WORK

Surprise Medical Bill Screening and Complaint Workbook

Determine which official help route may fit an unexpected out-of-network accident-care bill and prepare a factual complaint packet.

WHAT THIS WORKBOOK HELPS YOU DO

01

Complete your protection
screening

02

Complete your notice and
network evidence

03

Complete your bill comparison

For people handling accident-related paperwork and preparing clear, evidence-backed questions.

Use it on screen or on paper. Save a personal copy before entering information. Blank response areas are fillable; printed copies work just as well. Keep completed copies private.

Scope. Educational organization tools, not legal, medical, tax or financial advice. No claim result, coverage decision or payment is promised. Verify policy language, current local rules and all deadlines with the appropriate professional or official source.



START HERE

Start with a clear working file

Work on one claim, account or issue at a time. Keep originals unchanged and label working copies with a short evidence ID. Complete the guidance in order, then use the worksheets to turn questions into an organized next step.

A practical order

- 01** Read the four guidance pages before filling the worksheets. Mark facts you can support and questions that still need an answer.
GUIDANCE / PAGES 03-06
- 02** Use the fictional examples to check your method. Their facts and dollar amounts do not describe your claim or predict an outcome.
EXAMPLES / PAGE 07
- 03** Complete the four working sheets, then use the readiness check and next-step page. Duplicate a worksheet when you need another record.
WORKSHEETS / PAGES 08-11

Protect your information

Store completed copies somewhere private. Use a claim or account suffix when a full identifier is unnecessary. Share only relevant copies through a verified recipient and appropriate channel. A saved PDF can contain personal information even when it is not open on screen.

Before a deadline. Do not wait to finish this workbook when a notice, release, court paper or policy deadline needs attention. Verify the actual requirement and seek qualified help promptly.



GUIDANCE 1

01

Identify the kind of bill

Start with the service date, care setting, health coverage and biller. Unexpected does not automatically mean prohibited. A deductible bill, uncovered benefit, inaccurate account and out-of-network balance bill can look similar but follow different routes. Preserve the bill and explanation of benefits (EOB) together. This workbook helps identify questions for official assistance; it does not issue a legal ruling about the charge. Keep collection or court notices visible because a complaint may not pause separate obligations or deadlines.

Verify the coverage type

Record the plan name and whether the coverage is employer-based, individual, Medicare, Medicaid or another arrangement. Ask the plan administrator when the funding or regulatory category is unclear. The federal No Surprises Act has a defined scope, and public programs may use separate protections. Do not assume that a familiar insurer logo proves the plan is state-regulated. Retain the answer and source because the same billing facts can require a different complaint destination depending on the coverage arrangement.

RELATED WORKING SHEETS

- Protection screening
- Bill comparison

Sources for this page: [1], [2], [3]. See the linked source guide.



GUIDANCE 2

02

Map the care setting

Classify the encounter as emergency care, certain non-emergency services at an in-network facility, air ambulance or another setting. Record what you know and what must be verified; do not reinterpret clinical records to manufacture an emergency classification. Federal protections generally exclude ground ambulance bills, although state protections may apply. A narrow setting map is more useful than a blanket claim that every out-of-network bill after an accident is illegal. Separate multiple encounters so one eligible service does not appear to determine every other bill.

Preserve network and notice evidence

Collect the EOB's network designation, any provider directory information you actually relied on, appointment correspondence and any notice-and-consent form presented. Note when and how documents were received. Do not assume that any signature automatically waived all protections or that a signed form is automatically invalid. Some services cannot use the same consent exception as others. Preserve the full document and ask the official help channel to evaluate it. Never alter a form to improve the argument.

RELATED WORKING SHEETS

- Protection screening
- Notice and network evidence

Sources for this page: [1], [2], [3]. See the linked source guide.



GUIDANCE 3

03

Describe the disputed amount carefully

Keep the provider charge, plan payment, stated patient responsibility and amount demanded in separate fields. Identify which amount appears to be an extra out-of-network balance and the document supporting that concern. Avoid presenting the entire invoice as unlawful when part may represent ordinary cost sharing. If the plan has not processed the claim or the provider has issued a correction, record that status. A precise question about a defined amount gives the recipient something concrete to investigate.

Build a concise factual complaint

Use a neutral chronology: where care occurred, the coverage in force, what documents arrived, who you contacted and the discrepancy that remains. Attach relevant pages with labels and ask whether the applicable protection covers the service and which party should correct the charge. The consumer is not preparing the independent dispute resolution case used between providers and health plans. Keep the narrative factual and avoid threats or unsupported legal conclusions. Verify the complaint destination on the official current website before transmitting health or coverage information.

Identify the specific amount questioned and the document supporting it.



Sources for this page: [1], [2], [3]. See the linked source guide.



GUIDANCE 4

04

Track referrals without losing the issue

A help desk may route the matter to a state authority, plan regulator or another office. Record the referral, reason, case number and exact next step. Ask whether you must submit a new complaint and what evidence is needed. Keep a separate list of any insurance appeal or collection deadlines. Reusing the same factual packet can reduce effort, but do not assume a referral automatically transfers every attachment or extends a deadline. Confirm receipt at the new destination.

Verify the outcome

At resolution, compare the written response, revised EOB and updated provider statement. Check which service and amount were addressed and whether a remaining balance is explained. If the answer is that this protection does not apply, document the reason and the alternative route identified, such as state help or financial assistance. The workbook's success criterion is a supported resolution or clear handoff, not a guaranteed reduction. Preserve the original and corrected records so later statements can be checked against the outcome.

RELATED WORKING SHEETS

- Complaint and referral control
- Bill comparison

Sources for this page: [1], [2], [3]. See the linked source guide.



FICTIONAL EXAMPLES

Work through the examples

These invented cases demonstrate the method. They are not case results, estimates of what you will receive or statements of universal rights.

01 Fictional: air and ground services

One accident produces an out-of-network air-ambulance bill and a separate ground-ambulance bill. The federal screening routes them separately: covered air-ambulance services can fall within No Surprises Act protections, while ground transport generally requires checking other applicable protections. The workbook does not copy the air-service conclusion onto the ground bill.

02 Fictional: cost sharing versus extra balance

The EOB lists \$300 patient responsibility and a provider demands \$1,800. The complaint identifies the additional \$1,500 as the amount needing explanation and attaches the EOB. It does not assume the \$300 itself is prohibited or that the provider's demand is automatically unlawful.



WORKSHEET 1

01

Protection screening

Mark unknown rather than concluding eligibility from an insurer logo.

Service date

Coverage type

Funding/regulator confirmed by

Care setting

Facility network status

Provider network status

Air/ground ambulance

Known facts

Unresolved facts

Official route

Related guidance: [Identify the kind of bill](#)



WORKSHEET 2

02

Notice and network evidence

Keep full documents; this sheet does not determine consent validity.

Document name

Issuer

Date/time received

How provided

Full copy location

Signature/consent present

Directory information relied on

Service referenced

Question for reviewer

Related guidance: [Map the care setting](#)



WORKSHEET 3

03

Bill comparison

Separate suspected balance billing from ordinary cost sharing.

Provider/account

Service line

Charge

Plan payment

EOB patient amount

Provider demand

Amount questioned

Reason/source

Processing/revision status

Related guidance: [Describe the disputed amount carefully](#)



WORKSHEET 4

04

Complaint and referral control

Keep every referral tied to the same encounter and source packet.

Agency/plan

Verified URL/contact

Case number

Submission date/proof

Attachments

Question asked

Response

Referral destination

Separate deadlines

Corrected statement verified

Related guidance: [Track referrals without losing the issue](#)



READINESS REVIEW

Check the file before using it

REVIEW EACH ITEM BEFORE MOVING ON

- ☐ Each working figure or statement is linked to an identifiable document.
- ☐ Missing information is marked as unverified rather than estimated as fact.
- ☐ The exact question and the person or organization able to answer it are identified.
- ☐ The current document version and any conflicting version are preserved.
- ☐ Independent deadlines and the source of each deadline have been checked.
- ☐ The final written response has been compared with the original question.

What still needs attention

Open fact or decision, who can resolve it, and the source needed

Completion standard. The working file is complete when the important facts are supported, the next action is assigned and any unresolved issues remain clearly visible. A completed checklist does not establish coverage, entitlement or legal compliance.



ACTION PLAN

Write down the next step

Choose the smallest useful next step. Make the request specific enough that the recipient can locate the record and explain or address the exact issue. Keep proof of what you sent and what came back.

The exact issue or request

Evidence IDs and document versions that support the request

Verified recipient and channel

Date sent and follow-up date

What response will resolve the issue, and what still needs professional review

Separate decisions. A courtesy follow-up date is not a legal deadline. A document request does not automatically pause another requirement. Do not sign, settle, move property or disclose sensitive records merely because a box on this page is complete.



REFERENCE GUIDE

Sources and scope

The linked official sources support the educational background. The forms and examples are original organization tools. Sources were checked on October 1, 2026; policies, procedures and law may change. Recheck the current source before relying on a rule.

[1] Centers for Medicare and Medicaid Services

CMS distinguishes surprise-billing rights for private-insurance and self-pay situations, with coverage and setting limitations. Ground ambulance services generally are not protected by the federal law, subject to state rules.

<https://www.cms.gov/initiatives/your-patient-rights/medical-bill-rights/know-your-medical-bill-rights>

[2] U.S. Department of Labor

DOL explains protections for many emergency, certain non-emergency and air-ambulance services and discusses notice-and-consent limits. Coverage depends on the service and plan; every accident bill is not necessarily covered.

<https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/publications/avoid-surprise-healthcare-expenses>

[3] consumerfinance.gov

CFPB explains surprise-bill concepts and official consumer assistance routes; billing concerns and debt-collection issues can require different responses.

<https://www.consumerfinance.gov/ask-cfpb/what-is-a-surprise-medical-bill-and-what-should-i-know-about-the-no-surprises-act-en-2123/>

Keep the scope clear

Screening is not legal eligibility adjudication

State law, service setting, health plan type and exceptions matter

No medical classification or advice to refuse needed care