Oklahoma State Department of Health
Long Term Care
123 Robert S Kerr Ave, Suite 1702
Oklahoma City, OK 73012-6406
p. (405) 426-8200
f. (405) 900-7594

Independent Informal Dispute Resolution (IIDR) Request Form

In Accordance with Chapter 42 Code of Federal Regulations (CFR) §488.331& §488.431

Skilled nursing facilities (SNF), nursing facilities (NF) and skilled nursing facilities/nursing facilities (SNF/NF) must complete this form to dispute cited deficiencies which resulted in actual harm or immediate jeopardy to resident health or safety (i.e., at the Scope and Severity (S/S) level G or above) and which have had Civil Money Penalties (CMPs) imposed. CMPs may be collected by CMS and placed in an escrow account. If you have any questions, contact the IDR Coordinator by telephone at (405) 426-8200 or via e-mail at IDRCoordinator@health.ok.gov.

Submission

Complete this form, attach all documentary evidence relevant to each disputed deficiency and submit within **ten (10) calendar days** of receiving the Centers for Medicare/Medicaid Services (CMS) initial letter of imposition of a CMP related to a deficiency or deficiencies with a S/S of G or higher. Submit this form to Oklahoma State Department of Health, Long Term Care, Attention: IDR Coordinator, 123 Robert S Kerr Ave, Suite 1702, Oklahoma City, OK 73102-6406. **An IIDR will not be granted when a request form is incomplete or inaccurate. Documentary evidence submitted past the required timeframe will not be considered.**

IDR Type: (Check One) Face-to-Face Meeting ☐ Telephone/Virtual Conference ☐

Facility Name: ______________________________ Facility ID: ______________________

Facility Administrator: ______________________________ E-mail: ______________________

Mailing Address: ______________________________ Telephone Number: ( ) ______________

City: ______________________ Zip Code: __________ Facsimile Number: ( ) ______________

Date of CMS Notification of Imposition of CMP: ______/______/______ Survey Exit Date: ______/______/______

Dispute Description

Tag Number **S/S** **Explanation of Dispute** (Why is facility disputing the deficiency? List reason for each.)

A separate sheet may be attached, but must clearly identify the following: facility name, ID, survey exit date, tag number, scope & severity, and the explanation of dispute. All documentary evidence submitted must also identify these items.

1. __________ ____ ____

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2. __________ ____ ____

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3. __________ ____ ____

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Submitted by: ______________________________ Date: ______/______/______