Long Term Care
Protective Health Services

Oklahoma State
Department of Health

1000 Northeast Tenth Street
Oklahoma City, OK 73117
Phone (405) 271-6868
Fax (405) 271-3442

Independent Informal Dispute Resolution (IIDR) Request Form

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

To access the request form and process online click here.

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) 271-6868 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, 1000 NE 10th Street, Oklahoma City, OK 73117-1299. **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) Conducted by Independent Panel Face-to-Face Meeting* ☐ Telephone Conference ☐
*2-hour meeting limit.

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. _____ ____ _____

_____

2. _____ ____ _____

_____

3. _____ ____ _____

_____

Submitted by: _____ Date: _____/_____/_____