INFORMAL DISPUTE RESOLUTION (IDR) REQUEST

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF HEALTH FACILITIES
SFN 61109 (**10-16)**

This IDR is to be reviewed by:

ND Department of Health and Human Services
Health Facilities Staff
Mailing Address:
ND Department of Health
Division of Health Facilities
1720 Burlington Drive, Suite A
Bismarck, ND 58504 -7736
Fax: 701-328-1890

Directions:

1. The facility requesting the IDR must send a copy of this form to the North Dakota Dept of Health and Human Services, Health Facilities, within 10 calendar days following the receipt of the CMS 2567 deficiency statement.
2. All case documents and materials that you would like to be considered as a part of the IDR should be submitted to the organization.

Facility Name	Date Facility Received CMS-2567 Survey Report
Survey Exit Date	☐ Standard Survey ☐ Complaint Survey
SQC or Immediate Jeopardy identified during the Survey? ☐ Yes ☐ No	Event ID Number

☐ Desk ☐ Desk & Telephonic

1. List all tags (citations) requested for IDR (include scope and severity):

2. Attach to this form your factual evidence that you believe refute the requested tags (citations) for IDR. Please explain if the attached evidence was not available at the time of the survey:

Facility Contact Person	Telephone Number
E-mail Address	Date