



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: (Check One)

ND Department of Health
Division of Health Facilities Staff

OR

MPRO (Preliminary Review, followed
by final review by the NDDoH) -
Facility agrees to pay MPRO for
the preliminary review service.

Mailing Address:

ND Department of Health
Division of Health Facilities
600 East Boulevard Avenue Dept 301
Bismarck, ND 58505-0200
Fax: 701-328-1890

Mailing Address:

MPRO
IDR Department
22670 Haggerty Road, Suite 100
Farmington Hills, MI 48335-2611
Secure File Exchange: Refer to NDDoH
Website.

Directions:

1. The facility requesting the IDR must send a copy of this form to the NDDoH, Division of Health Facilities, within 10 calendar days following the receipt of the CMS 2567 deficiency statement.
2. If the facility selected the option for MPRO to complete the Preliminary Review option, a copy of this form should also be sent to MPRO, along with a signed service agreement and a signed HIPAA business associate agreement.
3. All case documents and materials that you would like to be considered as a part of the IDR should be submitted to the organization you selected above to complete the review. Please do not select both options.

Facility Name		Date Facility Received CMS-2567 Survey Report	
Survey Exit Date	<input type="checkbox"/> Standard Survey	<input type="checkbox"/> Complaint Survey	
SQC or Immediate Jeopardy identified during the Survey?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Desk		<input type="checkbox"/> 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	