INFORMAL DISPUTE RESOLUTION (IDR) OR INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR) REQUEST

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH FACILITIES
SFN 61109 (11-2026)

Click Here to Clear Field Data

The facility requesting the IDR or IIDR must send a copy of this form to Health and Human Services, Health Facilities within 10 calendar days following the receipt of the Statement of Deficiencies (CMS-2567).

All case documents and materials that you would like to be considered as a part of the IDR or IIDR must be submitted with this form.

Facility		
Date Facility Received the Statement of Deficiencies, CMS-2567		Survey Exit Date
Survey Type: Select one ◯ Standard Survey ◯ Complaint Survey		
Was Substandard Quality of Care or Immediate Jeopardy identified during the survey? ◯ Yes ◯ No		
Survey Event ID	Request Type: Select one ◯ IDR ◯ IIDR	Review Type: Select one ◯ Desk Only ◯ Desk and Conference Call
List all tags or citations requested for IDR or IIDR and include scope and severity		

Attach to this form your factual evidence that you believe refute the requested tags or citations for IDR or IIDR. Explain if the attached evidence was not available at the time of the survey.

Facility Contact Person	Telephone Number
Email Address	Date

Please return this form via fax or email:

Health and Human Services
Health Resources and Licensure
Health Facilities
Email: ndhf@nd.gov
Fax 701-328-1890