



**INFORMAL DISPUTE RESOLUTION (IDR) or INDEPENDENT INFORMAL
DISPUTE RESOLUTION (IIDR) REQUEST
HEALTH AND HUMAN SERVICES
HEALTH FACILITIES
SFN 61109 08-2026**

Directions

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 _____

☐ Standard Survey ☐ Complaint Survey

Substandard Quality of Care or Immediate Jeopardy identified during the survey? ☐ Yes ☐ No

Survey Event ID _____

Request Type ☐ IDR ☐ IIDR

Review Type ☐ 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. Please explain if the attached evidence was not available at the time of the survey.

Facility Contact Person _____

Email address _____

Telephone number _____ 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