



HEALTH RESOURCES AND SERVICES  
ADMINISTRATION

PROVIDER RELIEF BUREAU'S

DECISION REVIEW REQUEST PORTAL

USER GUIDE – REVIEW REQUEST SUBMISSION

**HRSA**  
Health Resources & Services Administration

USER GUIDE – REVIEW REQUEST SUBMISSION  
***PROVIDER RELIEF BUREAU'S  
DECISION REVIEW REQUEST PORTAL***

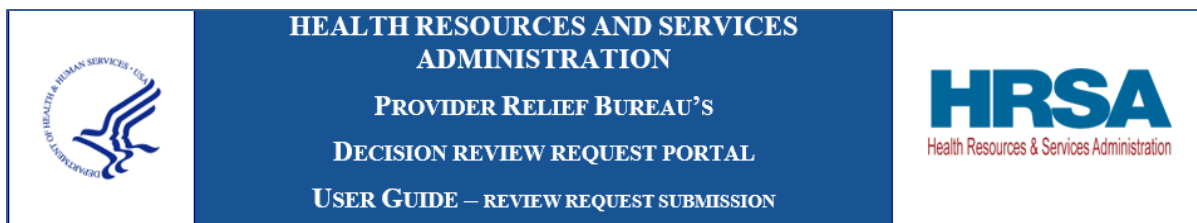
Date: November 21, 2023

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# **1 BACKGROUND INFORMATION, PURPOSE, AND GETTING STARTED**

## **1.1 BACKGROUND INFORMATION**

The Coronavirus Aid, Relief, and Economic Security (CARES) Act (P.L. 116-136), the Paycheck Protection Program (PPP) and Health Care Enhancement Act (P.L. 116-139), and the Coronavirus Response and Relief Supplemental Appropriations (CRRSA) Act (Division M of P.L. 116-260), and American Rescue Plan Act of 2021 (P.L. 117-2) appropriated funds to reimburse eligible healthcare providers for healthcare related expenses or lost revenues attributable to coronavirus. These funds were distributed by the Health Resources and Services Administration (HRSA) through the Provider Relief Fund (PRF) program. Recipients of these funds agreed to Terms and Conditions, which require compliance with reporting requirements as specified by the Secretary of Health and Human Services in program instructions.

## **1.2 PURPOSE**

The purpose of the Provider Relief Bureau (PRB) Decision Review (DR) Request Portal is to centralize, organize, track statuses, notify and communicate with providers who have been identified by HRSA as non-compliant with one or more of PRB's programs for one or more non-compliant categories; and to notify those providers of HRSA's pending action, and allow those non-compliant providers to appeal or dispute HRSA's pending action by:

- Submitting information and attaching justification documentation via webform.
- Returning their funds or by referring the provider to collections.

## **1.3 BEFORE STARTING**

The DR Request Portal is for providers who have received a final repayment notice letter from HRSA requesting repayment of funds associated with Provider Relief Fund (PRF) payments within 60 calendar days of the date of the letter. The letter will contain information needed to access and submit a request review in the DR Request Portal. The submission process must be completed in one session as it is not possible to save partially entered information.

Providers should ensure they have all the information required to register available before they begin. Information required to submit request:

1. Tax Identification number (TIN).

2. Repayment ID found in the final repayment notice received from HRSA.
3. The Repayment Amount specified in the final repayment notice received from HRSA.
4. The repayment amount provider is disputing (Whether it's the full repayment amount stated in the letter or a different amount).
5. A written narrative explaining why provider disagrees with HRSA's repayment decision in Adobe PDF/MS Word format.
6. Supporting documentation if applicable that substantiates provider's narrative. Formula-based documentation must be provided in Microsoft Excel or Microsoft Excel-compatible format.
7. Business name (as it appears on the Internal Revenue Service (IRS) Form W-9 of the Reporting Entity).
8. Provider Type.
9. Contact and/or Submitters information if different (First Name, Last Name, Phone number, Title, Email).
10. Address as it appears on the IRS Form W-9 (Street 1, Street 2, City, State, five-digit ZIP code) of the Reporting Entity.

Identified providers must submit their request no later than 60 calendar days from the date of the final repayment notice. Late decision review submissions will not be considered. Inability to submit your request within 60 days of the final repayment notice means the initial determination of non-compliance will be upheld and any identified debt will be sent for official collection.

## **1.4 GETTING STARTED**

The link to the PRB DR Request Portal is available in the final repayment notice or email received from HRSA.

## 2 PRB DR REQUEST PORTAL HOME PAGE

The PRB DR Request Portal home page allows providers to create a Decision Review Request.

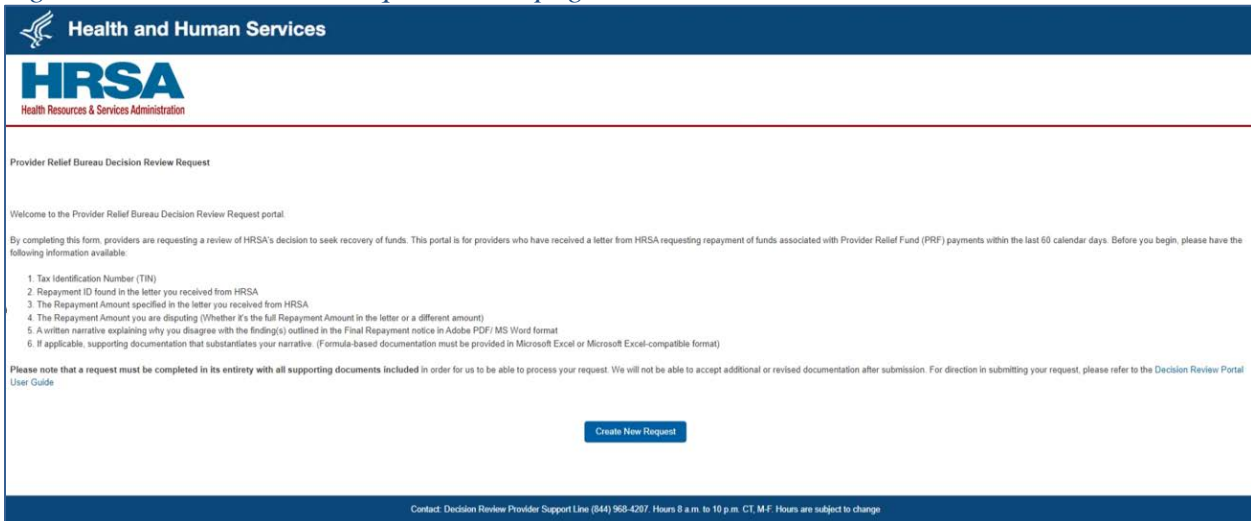
### 2.1 HOW TO ACCESS

The PRB DR Request Portal can be accessed by clicking on the link provided in the final repayment notice from HRSA. The PRB DR Request Portal is only compatible with the most current version of Microsoft Edge, Google Chrome, or Mozilla Firefox.

### 2.2 GENERAL LAYOUT

A screenshot of the PRB DR Request Portal home page is shown in *Figure 1 Decision Review Request Home page*.

*Figure 1 Decision Review Request Home page*



Health and Human Services

**HRSA**  
Health Resources & Services Administration

Provider Relief Bureau Decision Review Request

Welcome to the Provider Relief Bureau Decision Review Request portal.

By completing this form, providers are requesting a review of HRSA's decision to seek recovery of funds. This portal is for providers who have received a letter from HRSA requesting repayment of funds associated with Provider Relief Fund (PRF) payments within the last 60 calendar days. Before you begin, please have the following information available:

1. Tax Identification Number (TIN)
2. Repayment ID found in the letter you received from HRSA
3. The Repayment Amount specified in the letter you received from HRSA
4. The Repayment Amount you are disputing (Whether it's the full Repayment Amount in the letter or a different amount)
5. A written narrative explaining why you disagree with the finding(s) outlined in the Final Repayment notice in Adobe PDF/ MS Word format
6. If applicable, supporting documentation that substantiates your narrative (Formula-based documentation must be provided in Microsoft Excel or Microsoft Excel-compatible format)

Please note that a request must be completed in its entirety with all supporting documents included in order for us to be able to process your request. We will not be able to accept additional or revised documentation after submission. For direction in submitting your request, please refer to the Decision Review Portal User Guide

[Create New Request](#)

Contact: Decision Review Provider Support Line (844) 968-4207. Hours 8 a.m. to 10 p.m. CT, M-F. Hours are subject to change

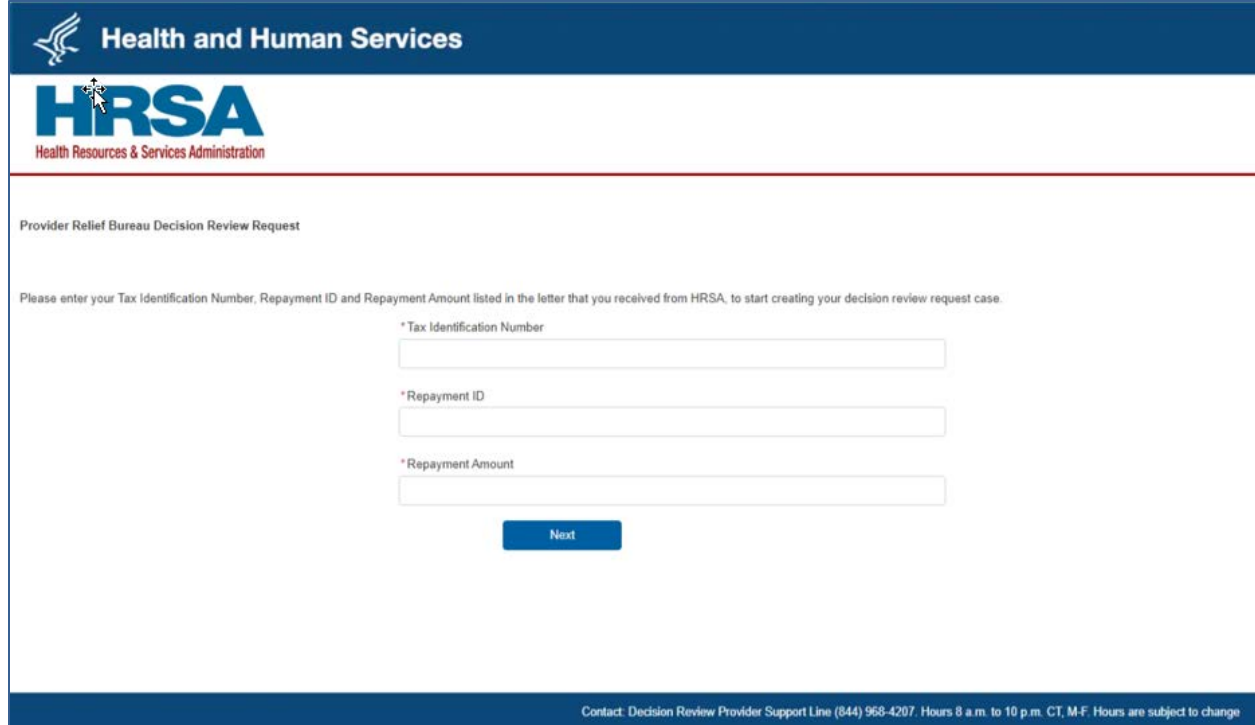
### 3 DECISION REVIEW REQUEST PROCESS

Accessing the DR URL is the first process required for providers to initiate their Decision Review Request. This section describes the steps involved to complete the review request process after portal users click the 'Create New Request' button on the PRB DR Request Portal home page.

#### 3.1 STEP 1 – PROVIDER VALIDATION INFORMATION

The first step of the submission process is shown in *Figure 2 Provider Validation Information*. This step requires that Providers share identifying information including the TIN, Repayment ID and Repayment Amount. This information can be found in the final repayment notice letter received from HRSA.

*Figure 2 Provider Validation Information*



Health and Human Services

**HRSA**  
Health Resources & Services Administration

Provider Relief Bureau Decision Review Request

Please enter your Tax Identification Number, Repayment ID and Repayment Amount listed in the letter that you received from HRSA, to start creating your decision review request case.

\* Tax Identification Number

\* Repayment ID

\* Repayment Amount

Next

Contact: Decision Review Provider Support Line (844) 968-4207. Hours 8 a.m. to 10 p.m. CT, M-F. Hours are subject to change

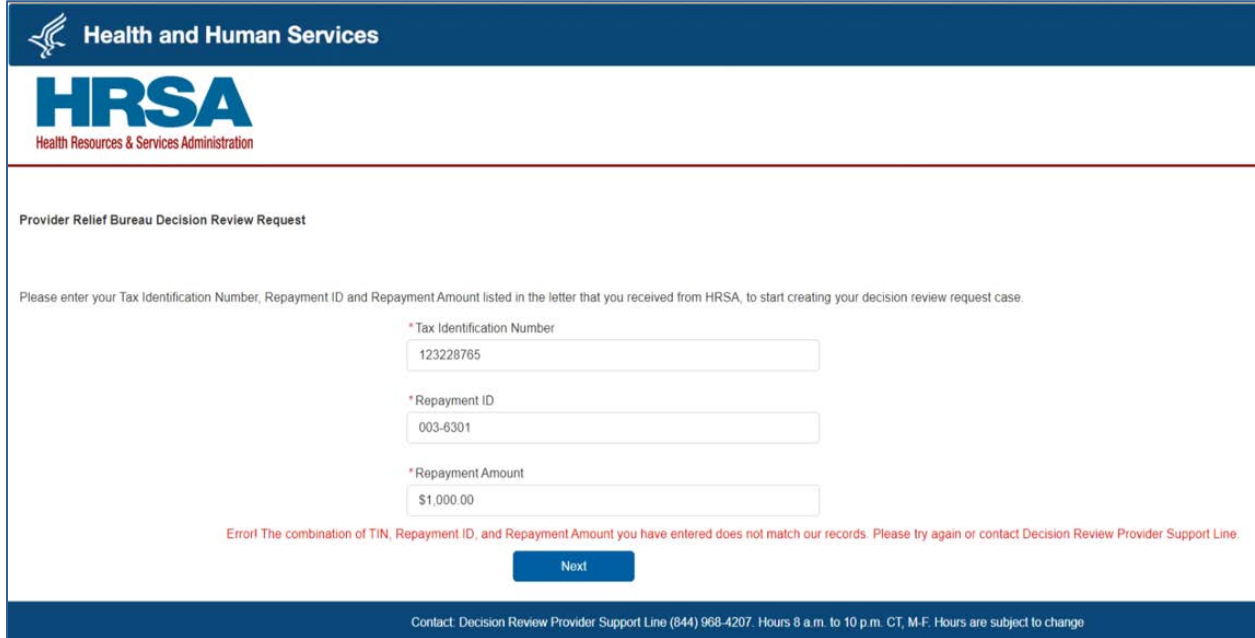
Portal users must enter all of the required information (marked by a red asterisk[ \* ]) and click 'Next' at the bottom of the page.

**The user will not be able to proceed to the next page until all required fields have been completed without errors.**

If the portal user continues to have difficulty entering information, they believe to be valid, they should contact the Decision Review Provider Support Line at (844) -968-4207.

If the user has not completed a required field, an error message in red will appear below the required data entry fields as shown in *Figure 3 Provider Validation Information – Required Field Error*.

*Figure 3 Provider Validation Information – Required Field Error*



Health and Human Services

**HRSA**  
Health Resources & Services Administration

Provider Relief Bureau Decision Review Request

Please enter your Tax Identification Number, Repayment ID and Repayment Amount listed in the letter that you received from HRSA, to start creating your decision review request case.

\* Tax Identification Number  
123228765

\* Repayment ID  
003-6301

\* Repayment Amount  
\$1,000.00

Error! The combination of TIN, Repayment ID, and Repayment Amount you have entered does not match our records. Please try again or contact Decision Review Provider Support Line.

Next

Contact: Decision Review Provider Support Line (844) 968-4207. Hours 8 a.m. to 10 p.m. CT, M-F. Hours are subject to change

After the system successfully validates information entered, user can click on the Next button to proceed to the next page. Information entered by portal users in the validation page will be saved and carried over to the next page. Users cannot edit this information once submitted as shown in *Figure 4 Provider Successful Validation Page*.

Figure 4 Provider Successful Validation Page

Health and Human Services

**Provider Relief Bureau Decision Review Request**

Success! Thank you for validating your Tax Identification Number, Repayment ID and Repayment Amount. Please fill out the form below to review, then submit to create your decision review request case.

**Additional details:**

- If you exit prior to submitting your request, your information will not be saved, and you will have to restart your request.
- The contact information is only used for communication related to your Decision Review Request.
- Click the "Review" button to confirm the information entered on this page.
- If you wish to exit the Decision Review Portal at any time, please close the browser window.

Provider Validation	Repayment ID	Repayment Amount
Tax Identification Number (TIN) 321394725	003-4792	\$100.00
Repay Group		
Test		

**Provider Information**

\*Business Name (as it appears on W9)

\*Provider Type

Address (as it appears on W9)

\*Street 1

Street 2

\*City

\*State

\*Zip Code

**Contact Information**

\*First Name

\*Last Name

\*Title

\*Email

\*Phone Number

Extension

Is the contact information same as submitter information?

**Submitter's Information**

\*First Name

\*Last Name

\*Title

\*Email

\*Phone Number

Extension

Is the amount you are disputing different from repayment amount listed in letter from HRSA?

\*Amount Being Disputed

\*Justification for Decision Review Request

You may upload a maximum of three (3) attachments. You will need to upload each file individually by using the upload button to search for your file. If you upload the incorrect file, you may delete attached files by clicking on the file name or trash can icon next to the file name.

Documents Attached

When attaching files, please name your file(s) to include your business name, Repayment ID (from your letter), and the contents of the file. Please see the tooltip for file name examples. (Accepted formats: XL, SX, XLS, CSV, PDF, DOC, DOCX)

Or drop files

You will not be able to resubmit your request for any reason. Please ensure that all information and attachments are accurate.

### 3.2 STEP 2 – PROVIDER IDENTITY INFORMATION

After completing the Provider Validation Information page, the portal user is taken to the Provider Demographics page as shown below in *Figure 5 Provider Demographics Page*.



Figure 5 Provider Demographics Page

Health and Human Services

---

**Provider Relief Bureau Decision Review Request**

Success! Thank you for validating your Tax Identification Number, Repayment ID and Repayment Amount. Please fill out the form below to review, then submit to create your decision review request case.

**Additional details:**

- If you exit prior to submitting your request, your information will not be saved, and you will have to restart your request.
- The contact information is only used for communication related to your Decision Review Request.
- Click the "Review" button to confirm the information entered on this page.
- If you wish to exit the Decision Review Portal at any time, please close the browser window.

<p><b>Provider Validation</b></p> <p>Tax Identification Number (TIN) 321394729</p> <p>Repay Group Test</p>	<p>Repayment ID 003-4792</p>	<p>Repayment Amount \$100.00</p>
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**Provider Information**

*Business Name (as it appears on W9) <input type="text"/>	*Provider Type Select Provider Type ▼	
--	--	--

**Address (as it appears on W9)**

*Street 1 <input type="text"/>	Street 2 <input type="text"/>	
*City <input type="text"/>	*State Select State ▼	*Zip Code <input type="text"/>

**Contact Information**

*First Name <input type="text"/>	*Last Name <input type="text"/>	*Title <input type="text"/>
*Email <input type="text"/>	*Phone Number <input type="text"/>	Extension <input type="text"/>

Is the contact information same as submitter information?

**Submitter's Information**

*First Name <input type="text"/>	*Last Name <input type="text"/>	*Title <input type="text"/>
*Email <input type="text"/>	*Phone Number <input type="text"/>	Extension <input type="text"/>

Is the amount you are disputing different from repayment amount listed in letter from HRSA?

\*Amount Being Disputed

**Justification for Decision Review Request**

You may upload a maximum of three (3) attachments. You will need to upload each file individually by using the upload button to search for your file. If you upload the incorrect file, you may delete attached files by clicking on the file name or trash can icon next to the file name.

When attaching files, please name your file(s) to include your business name, Repayment ID (from your letter), and the contents of the file. Please see the tooltip for file name examples. (Accepted formats: XL, SX, XLS, XLSX, CSV, PDF, DOC, DOCX)

Documents Attached

You will not be able to resubmit your request for any reason. Please ensure that all information and attachments are accurate.

Contact: Decision Review Provider Support Line (844) 968-4207. Hours 8 a.m. to 10 p.m. CT, M-F. Hours are subject to change.

This step requires that providers share identifying information including the business name (as it appears on IRS Form W-9), provider type, contact and/or submitter information, and address. The amount in dispute field is pre-populated with the Repayment Amount entered in the validation page. The provider is required to update the value in the amount in dispute field if different from the pre-populated repayment amount and attach justification documents. Justification documents should include a clear and concise written narrative in pdf format and

supporting documentation to substantiate the request for decision review. The file names should include the name of the business, repayment Id and contents of the file (**Example: yourbusinessname\_001-000001\_generalledger.xlsx**). User may upload a maximum of three attachments with a maximum 25MB per file. Formula-based documentation must also be provided in Microsoft excel or Microsoft excel-compatible format.

Portal users must enter all of the required information (marked by a red asterisk[ \* ]) and click 'Review' at the bottom of the page. If a user clicks the 'Review' button without providing information in a required field, an error message will appear in red below the required data entry fields as shown in *Figure 6 Provider Identity Information – Required Field Error*.

The user will not be able to proceed to the next page until all required fields have been completed without errors.

*Figure 6 Provider Identity Information – Required Field Error*

**Health and Human Services**  
**HRSA**  
Health Resources & Services Administration

Provider Relief Bureau Decision Review Request

Success! Thank you for validating your Tax Identification Number, Repayment ID and Repayment Amount. Please fill out the form below to review, then submit to create your decision review request case.

Additional details:

- If you exit prior to submitting your request, your information will not be saved, and you will have to restart your request.
- The contact information is only used for communication related to your Decision Review Request.
- Click the 'Review' button to confirm the information entered on this page.
- If you wish to exit the Decision Review Portal at any time, please close the browser window.

**Provider Validation**

Tax Identification Number (TIN) 321394729	Repayment ID 003-4792	Repayment Amount \$100.00
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Repay Group  
Test

**Provider Information**

\*Business Name (as it appears on W9)  
[Red error box]  
Please enter some valid input. Input is not optional.

\*Provider Type  
Select Provider Type [Red error box]  
Required field

**Address (as it appears on W9)**

\*Street 1  
[Red error box]  
Please enter some valid input. Input is not optional.

Street 2  
[Red error box]

\*City  
[Red error box]  
Please enter some valid input. Input is not optional.

\*State  
Select State [Red error box]  
Required field

\*Zip Code  
[Red error box]  
Min 5 numbers

**Contact Information**

\*First Name  
[Red error box]  
Please enter some valid input. Input is not optional.

\*Last Name  
[Red error box]  
Please enter some valid input. Input is not optional.

\*Title  
[Red error box]  
Please enter some valid input. Input is not optional.

\*Email  
[Red error box]  
Please enter some valid input. Input is not optional.

\*Phone Number  
[Red error box]  
Please enter some valid input. Input is not optional.

Extension  
[Red error box]

Is the contact information same as submitter information?

**Submitter's Information**

\*First Name  
[Red error box]  
Please enter some valid input. Input is not optional.

\*Last Name  
[Red error box]  
Please enter some valid input. Input is not optional.

\*Title  
[Red error box]  
Please enter some valid input. Input is not optional.

\*Email  
[Red error box]  
Please enter some valid input. Input is not optional.

\*Phone Number  
[Red error box]  
Please enter some valid input. Input is not optional.

Extension  
[Red error box]

Is the amount you are disputing different from repayment amount listed in letter from HRSA?  
\*Amount Being Disputed  
100

**\*Justification for Decision Review Request**  
You may upload a maximum of three (3) attachments. You will need to upload each file individually by using the upload button to search for your file. If you upload the incorrect file, you may delete attached files by clicking on the file name or trash can icon next to the file name.

Documents Attached


When attaching files, please name your file(s) to include your business name, Repayment ID (from your letter), and the contents of the file. Please see the tooltip for file name examples. (Accepted formats: XLSX, XLS, CSV, PDF, DOC, DOCX)

Upload Files Or drop files

You will not be able to resubmit your request for any reason. Please ensure that all information and attachments are accurate.

Review

Contact: Decision Review Provider Support Line (844) 955-4207. Hours 8 a.m. to 10 p.m. CT, M-F. Hours are subject to change.

Users should hover or click on the tooltip icon () to see additional details about the data entry fields. For some data entry fields, users are required to enter information in a particular format or style. For example, the phone number must consist of only ten digits and no special characters, such as brackets and dashes (‘(’, ‘)’, ‘-’); the user email address is not case sensitive (i.e., AbC123@xyz.org); the ZIP code must be five digits. After portal users have completed all of the required data entry fields without errors, they will be allowed to advance to the next page.

### **3.3 STEP 3 – PROVIDER INFORMATION REVIEW**

After completing the provider identity information page, the portal user is taken to the provider information review page. Providers will be presented with a review page based upon the information entered in previous pages as shown in *Figure 7 Provider Information Review*.

Figure 7 Provider Information Review

**Health and Human Services**  
**HRSA**  
Health Resources & Services Administration

Provider Relief Bureau Decision Review Request

**Review and Submit**  
Please review the information that you entered. If you need to make any corrections, please go back to the previous page for editing. Once you have confirmed that the information is accurate, please check the attestation box at the bottom of the page and submit your decision review request.

**Provider Validation**

Tax Identification Number (TIN) 321394729	Repayment ID 003-4792	Repayment Amount \$100.00
--	--------------------------	------------------------------

Repay Group  
Test

**Provider Information**

\* Business Name (as it appears on WS)  
Test

\* Provider Type  
Home and Community

Address (as it appears on W9)

\* Street 1  
123 test street

\* Street 2

\* City  
testville

\* State  
Alabama

\* Zip Code  
20009

**Contact Information**

\* First Name  
Test

\* Last Name  
Case

\* Title  
CEO

\* Email  
SNdel@hrsa.gov

\* Phone Number  
562333215

Extension

Is the contact information same as submitter information?

**Submitter's Information**

\* First Name  
Test

\* Last Name  
Case

\* Title  
CEO

\* Email  
SNdel@hrsa.gov

\* Phone Number  
562333215

Extension

Is the amount you are disputing different from repayment amount listed in letter from HRSA?  
\* Amount Being Disputed  
100

**Justification for Decision Review Request**  
You may upload a maximum of three (3) attachments. You will need to upload each file individually by using the upload button to search for your file. If you upload the incorrect file, you may delete attached files by clicking on the file name or trash can icon next to the file name.

Documents Attached  
Test doc.docx

When attaching files, please name your file(s) to include your business name, Repayment ID (from your letter), and the contents of the file. Please see the tooltip for file name examples. (Accepted formats: XLSX, XLS, CSV, PDF, DOC, DOCX)

**Attestation by Authorized Representative of Organization**  
By selecting the checkboxes below, I attest and understand that:

The PRB Decision Review process is not a reconsideration of my Provider Relief Fund (PRF) or American Rescue Plan (ARP) Rural payment.

I may not utilize the decision review process to request an opportunity to make edits or adjustments to a previously submitted report.

I have not previously submitted a decision review request for the Repayment ID stated above.

I understand that submitting this decision review request form does not guarantee the request will be approved, approval or denial or requests are subject to determination by HRSA.

I have submitted accurate and truthful information in the decision review request form.

You will not be able to resubmit your request for any reason. Please ensure that all information and attachments are accurate.

Contact: Decision Review Provider Support Line (844) 960-4207, Hours 8 a.m. to 10 p.m. CT, M-F. Hours are subject to change.

At this time, portal users will be able to review all the data entered throughout the request submission process for accuracy.

If a user determines that they need to change or update information displayed on this page, they should click the ‘Previous’ button to return to the Provider Demographics page to correct the inaccurate data. Data previously entered will not be lost unless the user closes their browser. The Tax Identification Number, Repayment ID and Repayment Amount fields cannot be edited.

If a user determines that all information displayed on this page is accurate, they must certify to the accuracy of the information by checking the attestation check boxes to activate and click on the ‘Submit’ button.

Figure 8 Completed Provider Information Review

Health and Human Services

---

**Provider Relief Bureau Decision Review Request**

**Review and Submit**

Please review the information that you entered. If you need to make any corrections, please go back to the previous page for editing. Once you have confirmed that the information is accurate, please check the attestation box at the bottom of the page and submit your decision review request.

<b>Provider Validation</b>	<b>Repayment ID</b>	<b>Repayment Amount</b>
Tax Identification Number (TIN) 321394729	003-4792	\$100.00
<b>Repay Group</b>		
Test		

**Provider Information**

* Business Name (as it appears on W9) <input type="text" value="Test"/>	* Provider Type Home and Community	
<b>Address (as it appears on W9)</b>	Street 2 <input type="text"/>	* Zip Code 20009
* Street 1 123 test street	* State Alabama	
* City testville		

**Submitter's Information**

* First Name <input type="text" value="Test"/>	* Last Name <input type="text" value="Case"/>	* Title <input type="text" value="CEO"/>
* Email <input type="text" value="SNode@hrsa.gov"/>	* Phone Number <input type="text" value="562333215"/>	Extension <input type="text"/>

Is the amount you are disputing different from repayment amount listed in letter from HRSA?  
\* Amount Being Disputed

**\* Justification for Decision Review Request**  
You may upload a maximum of three (3) attachments. You will need to upload each file individually by using the upload button to search for your file. If you upload the incorrect file, you may delete attached files by clicking on the file name or trash can icon next to the file name.

Documents Attached  
Test doc.docx

When attaching files, please name your file(s) to include your business name, Repayment ID (from your letter), and the contents of the file. Please see the tooltip for file name examples. (Accepted formats: XLSX, XLS, CSV, PDF, DOC, DOCX)

Or drag files

**Attestation by Authorized Representative of Organization**  
By selecting the checkboxes below, I attest and understand that:

- The PRB Decision Review process is not a reconsideration of my Provider Relief Fund (PRF) or American Rescue Plan (ARP) Rural payment.
- I may not utilize the decision review process to request an opportunity to make edits or adjustments to a previously submitted report.
- I have not previously submitted a decision review request for the Repayment ID stated above.
- I understand that submitting this decision review request form does not guarantee the request will be approved; approval or denial or requests are subject to determination by HRSA.
- I have submitted accurate and truthful information in the decision review request form.

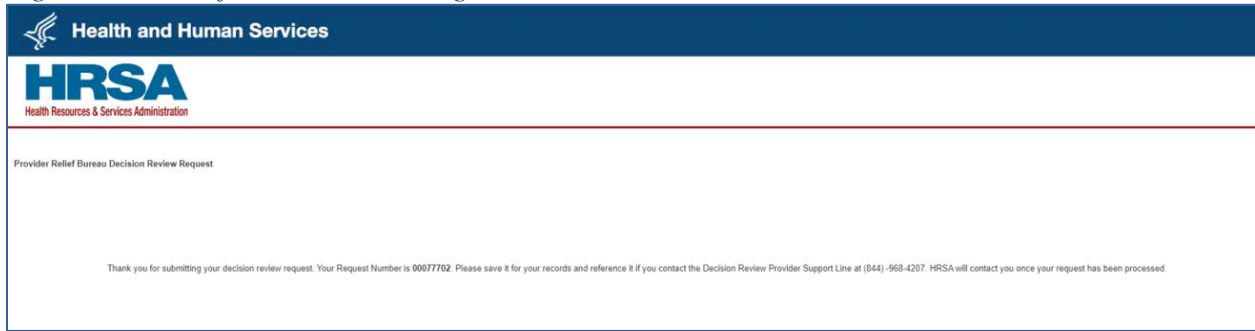
You will not be able to resubmit your request for any reason. Please ensure that all information and attachments are accurate.

Contact: Decision Review Provider Support Line (844) 968-4207, Hours 8 a.m. to 10 p.m. CT, M-F. Hours are subject to change

### 3.4 STEP 4 – DECISION REVIEW REQUEST SUBMISSION

Submission is complete after a provider certifies the accuracy of the information and clicks the ‘Submit’ button. Providers that successfully complete [Step 3 – Provider Information Review](#), will be directed to the final success page as shown in [Figure 9 Successful Submission Page](#) and an email confirmation will be sent to the submitters email address.

Figure 9 Successful Submission Page



Providers are unable to make any changes or upload any additional documentation once the review request is submitted successfully.

If the portal user requires any additional assistance after submission, they should contact the Decision Review Provider Support Line at (844) -968-4207 and provide their system generated Request Number.

**Once the Decision Review Request is created for a provider, the provider will not be able to re-access the URL link to submit a case using the same Tax Identification, Repayment ID and Repayment Amount combination.**

**Technical Questions and Language Assistance:** For technical questions regarding the use of the portal or questions regarding reporting that cannot be answered by this user guide or other available resources, portal users should contact the Decision Review Provider Support Line. The footer also has other web links to standard government websites and language assistance.