GOOD FAITH ESTIMATE

PATIENT

Full Name _____
First Name **Middle Name** **Last Name**

(PLEASE PRINT CLEARLY)

Patient Date of Birth _____ / _____ / _____

Patient ID Number _____

PATIENT ADDRESS, PHONE & EMAIL

Street or PO Box _____ **Apt. #** _____

City _____ **State** _____ **ZIP** _____

Phone Number _____ **Patient's Contact Preference** ☐ **Mail** ☐ **Email**

E-Mail _____

PATIENT DIAGNOSIS

Primary Service or Item Requested/Scheduled _____

Patient Primary Diagnosis _____ **Primary Diagnosis Code** _____

Primary Secondary Diagnosis _____ **Secondary Diagnosis Code** _____

If scheduled, list the date(s) the Primary service or item will be provided: _____

Check this box if this service or item is not yet scheduled ☐ **Date of Good Faith estimate:** ____ / ____ / ____

GOOD FAITH ESTIMATE

SERVICE	ADDRESS	DX CODE	SERVICE CODE	QUANTITY	EXPECTED COST

Disclaimer

The Good Faith Estimate shows the costs for items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.

If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill.

You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill or ask if there is financial assistance available.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process within 120 calendar days (about 4 months) of the date on the original bill.

There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount,

If you have questions, or want to learn more and get a form to start the process, go to www.cms.gov/nosurprises or call 1-877-696-6775.

Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.