Good Faith Estimate for Health Care Items and Services

Patient

Patient First Name Middle Name Last Name

Patient Date of Birth _____ Patient ID Number _____

Patient Mailing Address, Phone Number, and Email Address

Street or PO Box _____ Apartment _____
City _____ State _____ Zip Code _____
Phone _____
Email Address _____
Patient's Contact Preference: ❑By Mail ❑By Email ❑By Phone

Patient Diagnosis

Primary Service or Item Requested/Scheduled

Patient Primary Diagnosis	Primary Diagnosis Code
Patient Secondary Diagnosis	Secondary Diagnosis Code

If scheduled, list the date(s) the Primary Services or Item will be provided:

❑Check this box if this service or item is not yet scheduled

Date of Good Faith Estimate: _____

Summary of Expected Charges
(See the itemized estimate attached for more detail if applicable)

Provider Name	Estimated Cost
Total Estimated Cost: $	

Patient Signature(Guardian Signature): _____
Date: _____

ADDITIONAL SERVICES

Additional Service	Diagnosis Code

Attached is a detailed list of expected charges for your scheduled visit, as well as for items or services reasonably expected to be furnished in conjunction with the primary item or service as part of the period of care. These estimated costs are valid for 12 months from the date of the Good Faith Estimate.

DISCLAIMER

This Good Faith Estimate shows the costs of 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. This Good Faith Estimate does not cover any costs from external laboratories or pathology services that may be used.

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 cirumstances occur. If this happens and your bill is $400 or more for any provider or facility than your Good Faith Estimate for that provider or facility, federal law allows you to dispute the bill.

You may contact the healthcare provider or facility listed above 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 (HHC). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days(about 4 months) of the date on the original bill.

If you dispute your bill, the provider or facility cannot move the bill for the disputed item or service into collection or threaten to do so, or if the bill has already moved into collection, the provider or facility has to cease collection efforts. The provider or facility must also suspend the accrual of any late fees on unpaid bill amounts until after the dispute resolution process has concluded. The provider or facility cannot take or threaten to take any retributive action against you for disputing your bill.

There is a $25 fee to use the dispute process. If the Selected Dispute Resolution (SDR) entity reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate, reduced by the $25 fee. If the SDR entity disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

To learn more and get a form to start the process, go to www.cms.gov/nosurprises/consumers or call 1-800-985-3059.