

Good Faith Estimate

Patient Name:	Date of Birth:
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Estimated Services and Items		Date of Appointment		
Description (clear language)	Diagnosis Code (ICD-10 Code)	Service Code (CPT, HCPCS, DRG)	Quantity	Expected Cost
P - Primary Service (initial reason for visit) C – Co-provider services R - Reoccurring Services or item (valid for up to 12 months from date on this form)		Total Expected Charges		\$
		Date of Good Faith Estimate:		

Disclaimers:

There may be additional items or services that we recommend as part of the course of care that must be scheduled or requested separately and are not reflected in this good faith estimate.

The information provided in this good faith estimate is only an estimate of items or services reasonably expected to be furnished at the time this good faith estimate was and actual items, services, or charges may differ from the good faith estimate.

You have the right to initiate the patient-provider dispute resolution process if the actual billed charges are \$400 more than the expected charges included in the good faith estimate and the dispute is initiated within 120 days after the date of the bill for the items or services. To start the process, you may contact us at the phone number or address listed above to let us know the billed charges are higher than the Good Faith Estimate. You can ask us 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 within 120 calendar days (about 4 months) of the date on the original bill and if the agency disagrees with you, 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.

This good faith estimate is not a contract and does not require you to obtain the items or services from any of the providers or facilities identified in the good faith estimate.