INTAKEQ4U - GOOD FAITH ESTIMATE

Good Faith Estimate for Health Care Items and Services

1. Patient

First Name: Middle Initials: Last Name:

Date of Birth: Patient Identification Number:

2. Patient Mailing Address, Phone Number, and Email Address

Street Address: Apt./Unit #: City: State: Zip Code:

Mobile Phone: Email:

Patient's Contact Preference:
○ By mail ○ By email

3. 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 Service or Item will be provided:

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

Date of Good Faith Estimate:

Provider Name: Estimated Total Cost:

Provider Name: Estimated Total Cost:

Provider Name: Estimated Total Cost:

Total Estimated Cost: $

4. [Provider/Facility 1] Estimate

Provider/Facility Name: Provider/Facility Type:

Street Address: Apt./Unit #: City: State: Zip Code:

Contact Person: Phone: Email address:

5. Details of Services and Items for [Provider/Facility 1]

	Service/Item	Address where service/item will be provided	Diagnosis Code	Service Code	Quantity	Expected Cost
1						
2						
3						

6. Total Expected Charges from [Provider/Facility 1] $

Additional Health Care Provider/Facility Notes:

7. [Provider/Facility 2] Estimate

Provider/Facility Name: Provider/Facility Type:

Street Address: Apt./Unit #: City: State: Zip Code:

Contact Person: Phone: Email address:

8. Details of Services and Items for [Provider/Facility 2]

	Service/Item	Address where service/item will be provided	Diagnosis Code	Service Code	Quantity	Expected Cost
1						
2						
3						

9. Total Expected Charges from [Provider/Facility 2] $

Additional Health Care Provider/Facility Notes:

10. [Provider/Facility 3] Estimate

Provider/Facility Name: Provider/Facility Type:

Street Address: Apt./Unit #: City: State: Zip Code:

Contact Person: Phone: Email address:

11. Details of Services and Items for [Provider/Facility 3]

	Service/Item	Address where service/item will be provided	Diagnosis Code	Service Code	Quantity	Expected Cost
1						
2						
3						

12. Total Expected Charges from [Provider/Facility 3]$

Additional Health Care Provider/Facility Notes:

13.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.

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, you must start the dispute 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.

To learn more and get a form to start the process, go to

www.cms.gov/nosurprises/consum... or call 1-800-985-3059.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises/consum... or call 1-800-985-3059.

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.