[Facility/Provider Name]
[Address]
[City, State, Zip Code]
[Phone Number]

GOOD FAITH ESTIMATE FOR HEALTH CARE ITEMS AND SERVICES

Date of Estimate: [Date]

Patient Name: [Patient Name]
Date of Birth: [DOB]
Patient Identifier/MRN: [ID Number]

Summary of Expected Charges

The following is an estimate of the total expected cost for the items or services scheduled for [Date of Service] or requested on [Request Date].

Service Description	Service Code (CPT/HCPCS)	Estimated Cost
[Service 1]	[Code]	$[0.00]
[Service 2]	[Code]	$[0.00]
Total Estimated Cost:		**$[0.00]**

Provider/Facility Information:
Primary Provider: [Provider Name]
Tax ID: [TIN]
NPI: [NPI Number]

Important Disclaimers:

- This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for this visit. The estimate is based on information known at the time the estimate was created.
- This Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or exceptional circumstances occur.
- 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 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 for a lower price, or explain if any financial assistance packages are 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 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 selected dispute resolution entity reviews your dispute and agrees with you, you will have to pay the price on this Good Faith Estimate. If the entity disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit **www.cms.gov/nosurprises** or call [HHS Phone Number].

Patient Signature: _____ Date: _____