REVISED GOOD FAITH ESTIMATE FOR HEALTH CARE ITEMS AND SERVICES

Date of Revised Estimate: [Insert Date]

Original Estimate Date: [Insert Original Date]

Patient Information:
Patient Name: [Insert Name]
Date of Birth: [Insert DOB]
Patient ID/Reference: [Insert ID]

Provider/Facility Information:
Name: [Insert Name]
Address: [Insert Address]
Tax ID / NPI: [Insert Numbers]

Summary of Changes:
This revised estimate replaces the previous estimate provided to you. The changes are due to: [Insert Reason, e.g., change in scheduled procedure, addition of diagnostic tests, update in provider rates].

Estimated Service Details:

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

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.
- The actual items, services, or costs may differ from this estimate. For example, your provider may recommend additional services during treatment that were not anticipated.
- This estimate is not a contract and does not require you to obtain the items or services from this provider.

Patient Right to Dispute:
If you are billed for more than $400 over this Good Faith Estimate, you may have the right to dispute the bill through the patient-provider dispute resolution process. You must start the dispute process within 120 calendar days of receiving the original bill.

For questions about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call [Insert Facility Contact Number].