Good Faith Estimate for Health Care Items and Services

Date of Estimate: [Date]

Patient Name: [Patient Name]

Patient Date of Birth: [DOB]

Provider Information

Provider/Facility Name: [Name]

Tax ID Number: [TIN]

Business Address: [Address]

Contact Person: [Name/Phone]

Summary of Expected Charges

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for the upcoming year.

Service/Item Code	Description	Expected Cost
[CPT/HCPCS Code]	[Description of Service]	$[Amount]
[CPT/HCPCS Code]	[Description of Service]	$[Amount]
Total Estimated Cost:		**$[Total Amount]**

Important Disclaimers

- This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for the services listed.
- The estimate is based on information known at the time the estimate was created.

- This 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 estimate, ask for a lower price, or place the bill on hold.
- You can 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 of the date on the original bill.

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