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

**Date of Estimate:** [Insert Date]

# Good Faith Estimate for Diagnostic Imaging Services

**Patient Name:** [Patient First and Last Name]
**Date of Birth:** [Patient DOB]
**Patient Identifier/Account Number:** [Insert Number]

This Good Faith Estimate explains the costs of the diagnostic imaging services you are scheduled to receive. This estimate is based on information known at the time the estimate was created. It is not a contract and does not require you to obtain services from this facility.

| Service Description | CPT/HCPCS Code | Estimated Cost |
|---|---|---|
| [Name of Imaging Procedure, e.g., MRI Lumbar Spine] | [Insert Code] | $[0.00] |
| [Radiologist Reading/Professional Fee] | [Insert Code] | $[0.00] |
| [Other Related Fees, e.g., Contrast Material] | [Insert Code] | $[0.00] |
| **Total Estimated Cost:** | | **$[0.00]** |

**Scheduled Date of Service:** [Insert Date] (if applicable)

## Important Disclaimers:

- There may be additional items or services that are recommended as part of your care that must be scheduled or requested separately and are not reflected in this good faith estimate.
- The actual costs of the services may be higher than this estimate if complications or exceptional circumstances occur during the procedure.
- This estimate is only valid for 30 days from the Date of Estimate listed above.
- You have the right to initiate a patient-provider dispute resolution process if the actual billed charges are at least $400 more than this Good Faith Estimate. Initiating this process will not meddle with the quality of health care services you receive.

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

**Staff Signature:** _____