[Date]

[Patient Name]
[Patient Address]
[City, State, Zip Code]

Good Faith Estimate for Outpatient Procedure

Patient Date of Birth: [DOB]

Patient ID Number: [ID Number]

Scheduled Date of Service: [Date]

This Good Faith Estimate explains the costs of your upcoming outpatient procedure. This is only an estimate and not a final bill.

Service/Procedure Description	Medical Code (CPT/HCPCS)	Estimated Cost
[Procedure Name]	[Code]	$[0.00]
[Facility Fees]	[Code]	$[0.00]
[Anesthesia/Other Services]	[Code]	$[0.00]
Total Estimated Cost:		**$[0.00]**

Important Information:

- This estimate is based on information known at the time the estimate was created.
- Actual charges may vary depending on the care provided or complications that may arise during the procedure.
- If your final bill is $400 or more above this estimate, you have the right to dispute the bill through the patient-provider dispute resolution process.

For questions regarding this estimate, please contact: [Billing Department Name/Phone Number].

Sincerely,
[Provider/Facility Name]
[Contact Information]