Good Faith Estimate for Laboratory Services

Date of Estimate: [Insert Date]

Patient Name: [Insert Patient Name]

Patient Date of Birth: [Insert Date of Birth]

This Good Faith Estimate shows the costs of services that are reasonably expected for your laboratory testing. The estimate is based on information known at the time the estimate was created.

Service/Test Description	CPT Code	Estimated Cost
[Insert Test Name]	[Insert Code]	$[Insert Amount]
[Insert Test Name]	[Insert Code]	$[Insert Amount]
Total Estimated Cost:		**$[Insert Total]**

Provider Information

Laboratory Name: [Insert Lab Name]
Address: [Insert Address]
Tax ID / NPI: [Insert ID Numbers]

Important Disclaimers

- This estimate is not a contract and does not require you to obtain the services from this provider.
- The actual costs may differ from this estimate if additional tests are required based on clinical findings during processing.
- This estimate does not include any unknown or unexpected costs that may arise during treatment.
- If your actual bill is at least $400 more than this Good Faith Estimate, you have the right to dispute the bill through the patient-provider dispute resolution process.

For questions about this estimate, please contact: [Insert Contact Name/Department] at [Insert Phone Number].