GOOD FAITH ESTIMATE FOR CHRONIC DISEASE MANAGEMENT

Date of Estimate: [Insert Date]

Patient Information:
Name: [Patient Name]
Date of Birth: [DOB]
Patient ID: [ID Number]

Provider Information:
Provider Name: [Provider/Clinic Name]
Tax ID: [TIN Number]
NPI: [NPI Number]
Address: [Street, City, State, Zip]

Summary of Estimated Services:
This estimate outlines the expected costs for the ongoing management of your chronic condition(s) for the next 12 months. These services may include office visits, lab work, and routine monitoring.

Service/CPT Code	Description	Frequency (Annual)	Estimated Cost per Unit	Total Estimated Cost
[CPT Code]	Chronic Care Management	[e.g., 12]	$[0.00]	$[0.00]
[CPT Code]	Follow-up Office Visit	[e.g., 4]	$[0.00]	$[0.00]
[CPT Code]	Routine Lab Panels	[e.g., 2]	$[0.00]	$[0.00]
Total Estimated Annual Cost:				**$[0.00]**

Disclaimers:

- This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for the listed period.
- The estimate is based on information known at the time the estimate was created. It does not include unknown or unexpected costs that may arise during treatment.
- You may be charged more if complications or special circumstances occur.
- This estimate is not a contract and does not require you to obtain the services from this provider.
- If your actual bill is at least $400 more than this Good Faith Estimate, you may be eligible to dispute the bill via the patient-provider dispute resolution process.

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