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GOOD FAITH ESTIMATE FORM

From the No Surprises Act (Section 2799B-6 of the Public Health Act)

This Good Faith Estimate shows the costs of services that are reasonably expected for your psychological needs per service provided. The estimate is based on information known at the time the estimate is created.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.

If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill.

You may contact me/let me know if the billed charges are higher than the Good Faith Estimate. You can ask me to update your bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date of the original bill.

There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with me, you will have to pay the higher amount.

For questions or more information about your right to a Good Faith Estimate or the dispute process, go to www.cms.gov/nosurprises or call HHS at 1-877-696-6775.

KEEP A COPY OF YOUR GOOD FAITH ESTIMATE IN A SAFE PLACE OR TAKE PICTURES OF IT. You may need it if you are billed a higher amount.

A copy of the form we will complete at our first contact follows:

Good Faith Estimate for Health Care Items and Services

Patient		
Patient First Name	Middle Name	Last Name
Patient Date of Birth: ________/______/______		
Patient Identification Number:		
Patient Mailing Address, Phone Number, and Email Address		
Street or PO Box		Apartment
City	State	ZIP Code
Phone		
Email Address		
Patient's Contact Preference: [ ] By mail [ ] By email		
Patient Diagnosis		
Primary Service or Item Requested/Scheduled		
Patient Primary Diagnosis	Primary Diagnosis Code	
Patient Secondary Diagnosis	Secondary Diagnosis Code	

Good Faith Estimate

Provider/Facility Name		Provider/Facility Type
Street Address		
City	State	ZIP Code
Contact Person	Phone	Email
National Provider Identifier		Taxpayer Identification Number

Details of Services and Items for [Provider/Facility 3]

Service/Item	Address where service/item will be provided	Diagnosis Code	Service Code	Quantity	Expected Cost
	[Street, City, State, ZIP]	[ICD code]	[Service Code Type: Service Code Number]		

Total Expected Charges

If scheduled, list the date(s) the Primary Service or Item will be provided: [ ] Check this box if this service or item is not yet scheduled	
Date of Good Faith Estimate:	____________/________/___________
Provider Name	Estimated Total Cost
Provider Name	Estimated Total Cost
Provider Name	Estimated Total Cost
Total Estimated Cost: $	