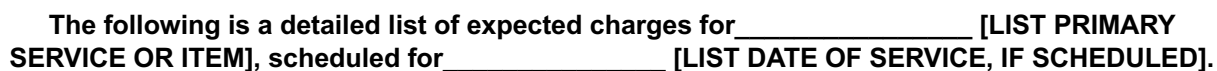




Good Faith Estimate for Health Care Items and Services

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		
City	State	Zip Code
Phone		
Email Address		
Patient's Contact Preference	<input type="checkbox"/> By mail	<input type="checkbox"/> By email
Patient Diagnosis		
Primary Service or Item Requested/Scheduled		
Patient Primary Diagnosis	Primary Diagnosis Code	
Patient Secondary Diagnosis	Secondary Diagnosis Code	
If scheduled, list the date(s), the Primary Service or Item will be provided <input type="checkbox"/> 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:		



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

[illegible]