Good Faith Estimate for Health Care Items and Services

Patient		
Patient Frist 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	**() By mail**	**() 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 () 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:		

The following is a detailed list of expected charges for_____ [LIST PRIMARY SERVICE OR ITEM], scheduled for_____ [LIST DATE OF SERVICE, IF SCHEDULED].

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 1]

Service/Item	Address where service/item will be provided	Diagnosis Code	Service Code	Quantity	Expected Cost