

Good Faith Estimate Form

For uninsured and self-pay patients under the No Surprises Act (45 CFR 149.610).

Issue within one business day of scheduling a service booked 3–9 business days ahead, or within three business days if booked 10+ days ahead or on request.

1. PATIENT INFORMATION

Patient full name: _____ Date of birth: _____ mm / dd / yyyy

Contact preference: ☐ Email ☐ Phone ☐ Mail

Estimate provided as: ☐ Paper ☐ Electronic

Street: _____ Apartment: _____

City: _____ State: _____ Zip code: _____

Email: _____ Phone: _____

2. ESTIMATE DETAILS

Date estimate issued: _____ mm / dd / yyyy Estimate number (if used): _____

Scheduling status: ☐ Scheduled ☐ Not scheduled (estimate requested)

Date of service, if scheduled: _____ mm / dd / yyyy

Recurring services, period covered (max. 12 months): _____

Primary service, in plain language:

3. DIAGNOSIS INFORMATION

Primary diagnosis: _____ Secondary diagnosis: _____

Diagnosis codes, ICD-10-CM (if required to calculate the estimate): _____

4. CONVENING PROVIDER OR FACILITY

The provider or facility that scheduled the service, or that received the request for this estimate.

Provider or facility name: _____ Provider type: _____

NPI: _____ TIN: _____

Service address: _____ State: _____

Contact person: _____ Phone: _____ Email: _____

Item or service	Service code (CPT/HCPCS)	Diagnosis code	Qty	Expected charge (\$)
Total expected charges for this provider or facility				

5. CO-PROVIDERS AND CO-FACILITIES (IF ANY)

Other providers or facilities expected to deliver items or services as part of the same care. List each one separately.

Co-provider or co-facility 1

Provider or facility name: _____ Provider type: _____

NPI: _____ TIN: _____

Service address: _____ State: _____

Item or service	Service code (CPT/HCPCS)	Diagnosis code	Qty	Expected charge (\$)
Total expected charges for this provider or facility				

Co-provider or co-facility 2

Provider or facility name: _____ Provider type: _____

NPI: _____ TIN: _____

Service address: _____ State: _____

Item or service	Service code (CPT/HCPCS)	Diagnosis code	Qty	Expected charge (\$)
Total expected charges for this provider or facility				

6. TOTAL ESTIMATED COST

Source	Expected charges (\$)
Convening provider or facility	
Co-providers and co-facilities	
Total estimated cost	

7. SERVICES TO BE SCHEDULED SEPARATELY

Items or services expected before or after the primary service that need separate scheduling, such as physical therapy after surgery. A separate good faith estimate will be issued for each when it is scheduled or requested.

Item or service	Expected timing

8. DISCLAIMER

This good faith estimate shows the costs of items and services that are reasonably expected for your care. It is based on information known at the time it was created. It does not include unknown or unexpected costs that may arise during treatment, and your actual items, services, or charges may differ from this estimate.

There may be additional items or services we recommend as part of your care that must be scheduled or requested separately. Those are not included in this estimate, and you will receive a separate estimate for them.

This good faith estimate is not a contract. It does not require you to get the items or services from any of the providers or facilities listed.

Your right to dispute a bill. If any provider or facility listed bills you at least \$400 more than its total on this estimate, you have the right to dispute the bill. You can:

- Contact that provider or facility, tell them the bill is higher than this estimate, and ask them to update the bill, negotiate it, or explain any financial assistance available.
- Start the patient-provider dispute resolution process with the U.S. Department of Health and Human Services. You must start it within 120 calendar days of the date on the original bill, and there is a \$25 administrative fee.

To learn more and get the form to start a dispute, visit www.cms.gov/nosurprises or call 1-800-985-3059.

Keep a copy of this estimate in a safe place, or take a photo of it. You may need it if you receive a bill for a higher amount.

9. ACKNOWLEDGMENT

Signing confirms that you received this estimate. It does not commit you to any service or charge.

Patient name: _____

Signature: _____ Date: _____ mm / dd / yyyy

For practice use: keep a copy of each estimate issued for at least six years. This template is a starting point, not legal advice. Adapt it to your practice and have it reviewed by your compliance advisor before use.