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

1

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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

 **Total Estimated Cost: $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Estimated Total Cost: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Estimated Total Cost: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Estimated Total Cost: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Good Faith Estimate: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**/**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**/**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

The following is a detailed list of expected charges for (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_),

 LIST PRIMARY SERVICE OR ITEM

Scheduled for (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_). (If items or services are reoccurring, “The

 LIST DATE OF SERCICE, IF SCHEDULED

Estimated costs are valid for 12 months from the date of the Good Faith Estimatee.”)

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DANIELS MEMORIAL HEALTHCARE CENTER 1 (Estimate)

National Provider Identifier Taxpayer Identification Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 81-6016920

Contact Person Phone Email

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (406) 487-2296 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City State ZIP Code

Scobey Montana 59263

Street Address

 105 5th Ave. E.

Provider/Facility Name Provider/Facility Type

**Detail of Services and Items for (Provider/Facility 1)**

Expected Cost

Quantity

Service Code

Type: CPT/CDM

Diagnosis Code

(ICD code)

Service Item

Address (street,city,state,ZIP)

(where service/item will be provided)

**Additional Health Care Procider/Facility Notes**

**Total Expected Charges From (Provider/Facility 1) $**

 

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To learn more and get a form to start the process, go to

[www.cms.gov/nosurprises or call 1-800-985-3059](http://www.cms.gov/nosurprises%20%20or%20call%201-800-985-3059).

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit [www.cms.gov/nosurprises](http://www.cms.gov/nosurprises) or call 1-800-985-3059.

