Daniels Memorial
HEALTHCARE CENTER

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

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 (_____). (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.")

Phone: 406.487.2296 | Fax: 406.487.2471 | PO Box 400 • 105 5th Avenue East, Scobey, MT 59263

DANIELS MEMORIAL HEALTHCARE CENTER 1 (Estimate)

Provider/Facility Name		Provider/Facility Type
Street Address 105 5th Ave. E.		
City Scobey	State Montana	ZIP Code 59263
Contact Person _____	Phone (406) 487-2296	Email _____
National Provider Identifier _____		Taxpayer Identification Number 81-6016920

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

Service Item	Address (street,city,state,ZIP) (where service/item will be provided)	Diagnosis Code (ICD code)	Service Code Type: CPT/CDM	Quantity	Expected Cost

Total Expected Charges From (Provider/Facility 1) $
Additional Health Care Procider/Facility Notes

Disclaimer

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was 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 the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the 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 on 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 the health care provider or facility, you will have to pay the higher amount.

To learn more and get a form to start the process, go to www.cms.gov/nosurprises or call 1-800-985-3059.
For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call 1-800-985-3059.

Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.