[NAME OF CONVENING PROVIDER OR CONVENING FACILITY]

Good Faith Estimate for Health Care Items and Services

Patient		
Patient First Name	Middle Name	Last Name
Patient Date of Birth: ____________/________/__________		
Account Number (last four digits) (optional):		
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 [ ] By phone		
Patient Diagnosis (if determined)		
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: ____________/________/__________	
Summary of Expected Charges (See the itemized estimate attached for more detail.)	
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[S] OF SERVICE, IF SCHEDULED] [[ADD IF ADDITIONAL ITEMS/SERVICES ARE BEING INCLUDED], as well as for items or services reasonably expected to be furnished in conjunction with the primary item or service as part of the period of care]. [Include if items or services are reoccurring, “The estimated costs are valid for 12 months from the date of the Good Faith Estimate.”]

[Provider/Facility 1] 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 (if required for the calculation of the GFE)	Service/Procedure Code	Quantity	Expected Cost
	[Street, City, State, ZIP]	[ICD code]	[Service/Procedure Code Type: Service/Procedure Code Number]		
Total Expected Charges from [Provider/Facility 1]				**$**	
Additional Health Care Provider/Facility Notes					

[Provider/Facility 2] Estimate [Delete if not needed]

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 2]

Service/Item	Address where service/item will be provided	Diagnosis Code (if required for the calculation of the GFE)	Service/Procedure Code	Quantity	Expected Cost
	[Street, City, State, ZIP]	[ICD code]	[Service/Procedure Code Type: Service/Procedure Code Number]		
Total Expected Charges from [Provider/Facility 2]				**$**	
Additional Health Care Provider/Facility Notes					

[Provider/Facility 3] Estimate [Delete if not needed]

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 3]

Service/Item	Address where service/item will be provided	Diagnosis Code (if required for the calculation of the GFE)	Service/Procedure Code	Quantity	Expected Cost
	[Street, City, State, ZIP]	[ICD code]	[Service/Procedure Code Type: Service/Procedure Code Number]		
Total Expected Charges from [Provider/Facility 3]				**$**	
Additional Health Care Provider/Facility Notes					

Total estimated cost for all services and items: $

Health Care Items/Services Expected to Be Separately Scheduled with Another Provider or Facility

DISCLAIMER: For health care items/services listed below, separate good faith estimates will be issued upon scheduling or upon request. Specific information such as the names and identifiers for the providers or facilities that may furnish the services, diagnosis codes (if required for the calculation of the GFE), service codes, and expected charges will be provided in separate good faith estimates once these items or services are scheduled (or upon request).

Service/Item	Provider/Facility [Instructions for obtaining a good faith estimate for the service/item, such as provider/facility name, address, phone number, and email]