ABC Health Center CONVENING FACILITY 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 *99205 New Patient Office Visit 99215 Established Patient Office Visit*		
Patient Primary Diagnosis		Primary Diagnosis Code
Patient Secondary Diagnosis		Secondary Diagnosis Code

Note 1) ICD 10 Diagnosis codes will be added after the patient is seen by the provider

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 Include National Provider Identifier, Tax Identification Number, and the location where the services will be provided	Estimated Total Cost *$250*
Provider Name	Estimated Total Cost
Provider Name	Estimated Total Cost
Total Estimated Cost: $ 250	

The following is a detailed list of expected charges for [LIST PRIMARY SERVICE OR ITEM], scheduled for [LIST DATE OF SERVICE, IF SCHEDULED]. [Include if items or services are reoccurring, “The estimated costs are valid for 12 months from the date of the Good Faith Estimate.”]

Add necessary disclaimers per CMS requirements

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