Letter Template: Self-Pay

Good Faith Estimate-Self Pay
National Provider Identifier (NPI): 1588606305)
Tax Identification Number (TIN): 521638592)

{DATESTAMP}

{PATIENT.LABELNAME}
{PATIENT.LABELADDRESS}

{INS_Name("P")}

Dear {PATIENT.NICKNAME],

Primary Services Requested/Scheduled:

[] Service not Scheduled	[] Medical	[] Behavioral Health/Substance Use
[] New/Est Dental	[] OB/GYN	[] LARC

Diagnosis:
Z76.89: Persons encountering health services in other specified circumstances

Next Appointment:
{APPTS_BY_STATUS("Confirmed","FULL")}
{APPTS_BY_STATUS("Scheduled","FULL")}

Estimated Total Cost:
The GFE applies to office visits for the selected services above that you have while a patient at our facilities. You will be covered for ##/##/####. This is considered your period of care. Any estimate cost is due at the time of service for each visit during your period of care.

Medical/GYN per visit - $110.00
Behavioral Health per visit, initial - $265.00-360.00
Behavioral Health/Substance Use per visit, ongoing - $125.00-$190.00
Behavioral Health/Substance Use group per visit, ongoing - $80.00
Dental Initial Assessment - $150-$245.00
Dental Subsequent Visits – will be calculated at the time of scheduling any follow-up
Pharmacy Charges – will be provided after pharmacy visit

<u>Disclaimer</u>
This Good Faith Estimate shows the cost of items and services that are reasonably expected for your health needs for an item or service. The estimate is based on information known at the time the estimate was created.

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The Good Faith Estimate does not include any unknown or unexpected costs 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 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 the 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 877-696-6775. For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises, or call 877-696-6775.

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