Letter Template: Good Faith Estimate – OB/GYN/MFM

Good Faith Estimate (GFE) for Health Care Items and Services
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 Patient	[] OB/GYN	[] LARC

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

Estimated Total Cost:

This GFE applies to all recurring office visits for the selected services above that you may have while you are covered by our assistance program. You will be covered for the dates of [##/##/####-##/##/####) by the program, this is considered your period of care. Any estimated cost is due at the time of service for each visit during your period of care.

OB Services (Indicate correct contract level below):
[] SFS Level A: $1,000 per pregnancy
[] SFS Level B: $1,050 per pregnancy
[] SFS Level C: $1,130 per pregnancy
[] SFS Level D: $1,230 per pregnancy
[] SFS Level E: $2,200 per pregnancy
[] N/A – Ultrasound/MFM Consult Only

Ultrasound/MFM Consult (Indicate correct contract level):
[] SFS Level A: $60.00
[] SFS Level B: $90.00
[] SFS Level C: $120.00
[] SFS Level D: $165.00
[] SFS Level E: $210.00
[] SFS Level F: $255.00

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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 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 them 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 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.