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| **GOOD FAITH ESTIMATE FOR HEALTH CARE ITEMS AND SERVICES** |
| **DATE OF GOOD FAITH ESTIMATE \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_** |
| **Patient**  |
| Patient First Name Middle Name Last Name DOB \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_  |
| **Patient Mailing Address, Phone Number and Email Address** |
| Street/PO Box Apartment |
| City State ZIP Code |
| Phone |
| Email Address |
| **Patient Diagnosis** |
| Primary Service Scheduled |
| Primary Diagnosis Primary Diagnosis Code |
| Secondary Diagnosis Secondary Diagnosis Code |
| If scheduled, list the date the Primary Service will be provided: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ **[ ]** is not yet scheduled |
| **Estimated Cost** |
| Provider Name Estimated Total Cost $ |
| Provider Name Estimated Total Cost $ |
| **Total Estimated Cost: $** |
| Acknowledgement of receipt of Good Faith Estimate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(name) |

The above is a detailed list of expected charges for your service. The total estimated cost will be submitted to your insurance company. If Dr. Kennedy participates with your insurance company, you will be directly responsible for the allowable out of pocket costs associated with your surgery (copay, coinsurance, deductible) as outlined by your insurance contract.

If Dr. Kennedy does not participate with your insurance company. The total estimated cost will be submitted to your insurance company and you will be directly responsible for some or all of the total estimated costs after payment by your insurance company.

**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 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/consumers 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/consumers or call 1-800-985-3059.

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| 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. |

For questions regarding other facility, lab, X-ray or anesthesia and Good Faith Estimates associated with your surgery, contact the following:

**Tri-State Surgery Center:**  563-584-4509

**Dubuque Anesthesia:** 563-556-8332

**Unity Point Finley Hospital:** 563-589-2388

**Grandview Anesthesia:** 208-241-9109 or 877-746-7090