ATTACHMENT D

STANDARD FORM: "GOOD FAITH ESTIMATE FOR HEALTH CARE ITEMS AND SERVICES" UNDER THE NOSURPRISES ACT

Instructions

(For use by health care providers no later than January 1, 2022)

Under Section 2799B-6 of the Public Health Service Act, health care providers and health care facilitiesare required to provide a good faith estimate of expected charges for items and services to individuals who are not enrolled in a plan or coverage or a Federal health care program, or not seeking to file a claim with their plan or coverage both orally and in writing, upon request or at the time of schedulinghealth care items and services.

This form may be used by the health care providers and facilities to inform individuals who are not enrolled in a plan or coverage or a Federal health care program (***uninsured individuals***), or individuals who are enrolled but not seeking to file a claim with their plan or coverage (***self-pay individuals***) of the expected charges they may be billed for receiving certain health care items and services. A good faith estimate must be provided within 3 business days upon request. Information regarding scheduled items and services must be furnished within 1 business day of scheduling an item or service to be provided in 3 business days; and within 3 business days of scheduling an item or service to be provided in at least 10 business days.

Additionally, Indiana law requires providers and facilities to continue to follow the requirements in Ind. Code 27-1-46-11 and provide a good faith estimate to ***covered individuals*** enrolled in a plan or otherwise have health care coverage (excluding Medicaid recipients) for ordered, scheduled or referred non-emergency services. This form has been adapted to meet the requirements of Indiana law and may also be used by providers and facilities to inform covered individuals (excluding Medicaid recipients) of the expected charges they may be billed for health care items and services. A good faith estimate must be provided to a covered individual for whom non-emergency health care services have been ordered, scheduled or referred, within 5 business days of receiving a request from such individual or 5 business days after receiving relevant information from the individual.

To use this model notice, the provider or facility must fill in the blanks with the appropriate information.HHS considers use of the model notice to be good faith compliance with the good faith estimate requirements to inform an individual of expected charges. Use of this model notice is not required and is provided as a means of facilitating compliance with the applicable notice requirements. However, some form of notice, including the provision of certain required information, is necessary to begin the patient-provider dispute resolution process.

NOTE: The information provided in these instructions is intended only to be a general informal summary of technical legal standards. It is not intended to take the place of the statutes, regulations, orformal policy guidance upon which it is based. Readers should refer to the applicable statutes, regulations, and other interpretive materials for complete and current information, including the Requirements Related to Surprise Billing; Part II interim final rule which provides the official requirements related to the good faith estimate.

Health care providers and facilities should not include these instructions with the documents givento patients.

[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: _____/_____/_____		
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		
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:	_____/_____/_____
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 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."]

[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	Service Code	Quantity	Expected Cost
	[Street, City, State, ZIP]	[ICD code]	[Service Code Type: Service 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	Service Code	Quantity	Expected Cost
	[Street, City, State, ZIP]	[ICD code]	[Service Code Type: Service 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 2]

Service/Item	Address where service/item will be provided	Diagnosis Code	Service Code	Quantity	Expected Cost
	[Street, City, State, ZIP]	[ICD code]	[Service Code Type: Service Code Number]		

Total Expected Charges from [Provider/Facility 2] $
Additional Health Care Provider/Facility Notes
Total estimated cost for all services and items: $

Disclaimer

This Good Faith Estimate is provided in good faith, based on information known at the time, and is our best estimate of the intended charges for the costs of items and services that are reasonably expected for your health care needs. The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. The estimate is non-binding and charges may vary from the estimate based on your medical needs or if complications or special circumstances occur.

This estimate is only valid for 30 days. If the actual charge for these services exceeds our estimate by the greater of: (i) $100; or (ii) 5%, we will provide a written explanation as to why the charges exceed the estimate.

If you are uninsured or do not intend to submit your charges to your health plan ("self-paying") and you are billed at least $400 more than this Good Faith Estimate, you have the right to dispute the bill.

If you are uninsured or self-paying, you may contact the health care provider or facility to let them know the billed charges are higher than the Good Faith Estimate and 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.

Uninsured or self-paying individuals may also start a dispute resolution process for uninsured with the U.S. Department of Health and Human Services (HHS). If you choose to do so, 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 resolution process for uninsured and self-paying individuals. If the agency reviewing yourdispute 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 this process, go to www.cms.gov/nosurprises 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 or call 1-800-985-3059.

Keep a copy of this Good Faith Estimate in a safe place or take pictures of it.