

Good Faith Estimate

Name		
Date of Birth		
Age	Gender	
Complete address		
Email address	Contact number	
Diagnosis		
Primary diagnosis	Code	
Secondary diagnosis	Code	
Good Faith Estimate		
Date:		
Service	Description	Estimated cost
1.		
2.		
3.		
4.		
5.		
6.		

7.		
8.		
9.		
10.		
Estimated total cost		

This is a comprehensive breakdown of anticipated expenses for (primary service or item), which is planned for (date and time). Please note that the projected costs are valid for up to 12 months from the date of the Good Faith Estimate.

Prepared by:

(sign over printed name)

Date:

Acknowledged by:

(sign over printed name)

Date: