No Surprises Act Job Aid

Standard Notice – Right to Receive a Good Faith Estimate of Expected Charges

Effective Date: January 1, 2022

What to Know:

Health care providers and health care facilities are required to inform individuals who are not enrolled in a plan or coverage or a Federal health care program (Uninsured), or not seeking to file a claim with their plan or coverage (Self-Pay/Cosmetic) both orally and in writing of their ability, upon request or at the time of scheduling health care items and services, to receive a "Good Faith Estimate" of expected charges.

Facility CEO/Administrators immediate actions:

- Update the Good Faith Estimate for Health Care Items and Services Form per the instructions below. Complete all bracketed areas and save a copy to your public drive for continued use.
- Establish an internal process for the completion and distribution of the notice within the required timelines outlined below.
- Print and Post in your facility the "You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost"
- Confirm the "Good Faith Estimate" notice has been posted to your facility website on 1/1/2022.

Good Faith Estimate Form requirements:

This form should be used by health care providers to inform individuals who are not enrolled in a plan or coverage or a Federal health care program (uninsured individual), or individuals who are enrolled but not seeking to file a claim with their plan or coverage (self-pay individuals) of their right to a "Good Faith Estimate" to help them estimate the expected charges they may be billed for receiving certain health care items or services.

Data elements the facility is required to include in the good faith estimate:

DATA ELEMENT	DESCRIPTION
Patient name and date of birth	First name, Last name, and date of birth for the uninsured (or self-pay) individual receiving items or services
Description of the primary procedure in clear and understandable language, and DOS if applicable	Description of the procedure and DOS
Items and services reasonably expected to be furnished for the period of care	An itemized list of services reasonably expected to be furnished by the facility, and items or services expected to be furnished in conjunction with and in support of the primary service.
Service Codes	Description of the procedure using the CPT, HCPCS, DRG or NDC codes

Diagnosis Codes	Primary ICD-10 code
Expected Charges	Expected charges associated with each listed item or service
Name of Facility	Facilities Legal Name as written on their business license
Tax ID Number	Facilities Taxpayer ID Number
National Provider Identifier (NPI)	Facilities National Provider Identifier (NPI)
List of items and services requiring separate scheduling	List of items or services that the facility anticipates will require separate scheduling and with either occur prior to or following the expected care.
Facility Location	Physical address of the facility, including street name and number, city, state, and zip code
Disclaimer Information:	
Good Faith Estimate is an estimate and subject to change	Provided on the last page of the Good Faith Estimate
There may additional items or services not contained in the good faith estimate	Provided on the last page of the Good Faith Estimate
Right to initiate the patient-provider dispute resolution process	Provided on the last page of the Good Faith Estimate
Good Faith Estimate is not a contract	Provided on the last page of the Good Faith Estimate

A sample form is provided along with this job aid, but you may create your own Good Faith Estimate form if it includes the required data elements.

Good Faith Estimate Timeline requirements:

- Must be provided within 3 business days upon request.
- If scheduled within 3 business days of DOS, estimate must be provided within 1 business day.
- If scheduled within 10 business days of DOS, estimate must be provided within 3 business days.

Availability of a Good Faith Estimate:

To ensure the public is aware of the information regarding the availability of a "Good Faith Estimate", The "You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost" signage must be prominently displayed (attached on the next page):

- Provider/facility website homepage will include the disclosure notice or a link to access it
  - Websites managed by USPI will be automatically updated on 1/1/2022 with notices posted in the "For Patients" section.
  - If your website is **NOT** managed by USPI, please work with your website administrator to have this added by 1/1/2022.
- Patient Registration
- Scheduling department
- Patient Check-In
- Cashier

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This must be posted in your facility and on your website

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost

Under the law, health care providers need to give **patients who don't have insurance or who are not using insurance** an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.

- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.

- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.

- Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call 1-800-985-3059.

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This must be provided to the individual prior to service

[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	

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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."]

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[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

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Provider/Facility Name		Provider/Facility Type
Street Address		
City	State	ZIP Code
Contact Person	Phone	Email
National Provider Identifier		Taxpayer Identification Number

[Provider/Facility 2] Estimate [Delete if not needed]

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]		

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Total Expected Charges from [Provider/Facility 2] $
Additional Health Care Provider/Facility Notes

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[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 3]

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 3]$

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Additional Health Care Provider/Facility Notes
Total estimated cost for all services and items: $

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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 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 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 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 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. You may need it if you are billed a higher amount.