Sample Good Faith Estimate for Uninsured (or Self-Pay) Individuals

Below is an example of a good faith estimate form for uninsured (or self-pay) individuals who are expected to receive a bill for their care. This sample form highlights key information that is required by the No Surprises Act. Providers and facilities do not have to use this specific form, as long as they use a form that includes the required information. For a full list of good faith estimate requirements, see the regulatory requirements at 45 CFR § 149.610(c). To access the form, see the Good Faith Estimate for Health Care Items and Services template.

[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: _____/_____/_____		
Account Number (last four digits) (optional):		
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 [ ] By phone		
Patient Diagnosis (if determined)		
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		

The form must include information such as the patient's name, date of birth, and the primary item or service (with diagnosis codes).

This document is intended to provide clarity to the public about requirements related to surprise billing. It does not have the force and effect of law.

Revision Date: 8/2023

Sample Good Faith Estimate for Uninsured (or Self-Pay) Individuals

[Provider/Facility 3] Estimate [Delete if not needed]

Provider/Facility Name	Provider/Facility Type

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

Provider/Facility Name	Provider/Facility Type

[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 (if required for the calculation of the GFE)	Service/Procedure Code	Quantity	Expected Cost
	[Street, City, State, ZIP]	[ICD code]	[Service/Procedure Code Type: Service/Procedure Code Number]		
Total Expected Charges from [Provider/Facility 1] $					
Additional Health Care Provider/Facility Notes					

The good faith estimate must include a list of items or services that are reasonably expected to be furnished for the period of care.

This list must be grouped by provider. The No Surprises Act requires the estimate to describe the items and services that will be provided by the convening provider as well as items and services that will be provided by any co-providers or co-facilities.

However, the federal government currently is not enforcing the requirement for co-providers and co-facilities, so individuals may still receive an estimate that does not contain information from co-providers or co-facilities.

Health Care Items/Services Expected to Be Separately Scheduled with Another Provider or Facility

DISCLAIMER: For health care items/services listed below, separate good faith estimates will be issued upon scheduling or upon request. Specific information such as the names and identifiers for the providers or facilities that may furnish the services, diagnosis codes (if required for the calculation of the GFE), service codes, and expected charges will be provided in separate good faith estimates once these items or services are scheduled (or upon request).

Service/Item	Provider/Facility [Instructions for obtaining a good faith estimate for the service/item, such as provider/facility name, address, phone number, and email]

Good faith estimates must include a list of items or services that will require separate scheduling. These items or services are expected to be provided before or after the period of care for the primary item or service. For example, physical therapy following knee surgery.

Sample Good Faith Estimate for Uninsured (or Self-Pay) Individuals

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, and your bill is $400 or more for any provider or facility than your Good Faith Estimate for that provider or facility, federal law allows you to dispute the bill.

The Good Faith Estimate is not a contract and does not require the uninsured (or self-pay) individual to obtain the items or services from any of the providers or facilities identified in the Good Faith Estimate.

If you are billed for more than this Good Faith Estimate, you may 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.

If you dispute your bill, the provider or facility cannot move the bill for the disputed item or service into collection or threaten to do so, or if the bill has already moved into collection, the provider or facility has to cease collection efforts. The provider or facility must also suspend the accrual of any late fees on unpaid bill amounts until after the dispute resolution process has concluded. The provider or facility cannot take or threaten to take any retributive action against you for disputing your bill.

There is a $25 fee to use the dispute process. If the Selected Dispute Resolution (SDR) entity reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate, reduced by the $25 fee. If the SDR entity 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, email FederalPPDRQuestions@cms.hhs.gov, 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.

PRIVACY ACT STATEMENT: CMS is authorized to collect the information on this form and any supporting documentation under section 2799B-7 of the Public Health Service Act, as added by section 112 of the No Surprises Act, title I of Division BB of the Consolidated Appropriations Act, 2021 (Pub. L. 116-260). We need the information on the form to process your request to initiate a payment dispute, verify the eligibility of your dispute for the PPDR process, and to determine whether any conflict of interest exists with the independent dispute resolution entity selected to decide your dispute. The information may also be used to: (1) support a decision on your dispute; (2) support the ongoing operation and oversight of the PPDR program; (3) evaluate selected IDR entity's compliance with program rules. Providing the requested information is voluntary. But failing to provide it may delay or prevent processing of your dispute, or it could cause your dispute to be decided in favor of the provider or facility.

The good faith estimate must include a number of disclaimers. For example, it must state that the estimate is based on information known at the time it was created. Therefore, it won't include any costs for unanticipated items or services that are not reasonably expected and that could occur due to unforeseen events.

The good faith estimate must also explain that individuals have a right to initiate the Patient-Provider Dispute Resolution process if the billed charges from a provider or facility are $400 or more than the estimate from that provider or facility.

Individuals should keep any estimate provided in a safe place to compare with any bills received later, in case they wish to dispute a bill through the Patient-Provider Dispute Resolution process. For more information, see background information on what's a good faith estimate, examples of good faith estimates that do and don't qualify for the dispute process as well as the Decision Tree: Requirements for Good Faith Estimates for Uninsured (or Self-Pay) Individuals and the Decision Tree: Patient-Provider Dispute Resolution Process.