OMB Control Number: 0938-NEW
Expiration Date: XX/XXXX

# APPENDIX 11

## Good Faith Estimates
## Data Elements

Under Section 2799B-7 of the Public Health Service Act and its implementing regulations, the U.S. Department of Health & Human Services (HHS) is required to establish a patient-provider dispute resolution process where a SelectedDispute Resolution (SDR) entity can resolve a payment dispute between individuals who are not enrolled in a group health plan, or group or individual health insurance coverage, or a Federal health care program, or a Federal Employees Health Benefits (FEHB) program health benefits plan (uninsured individuals), or who are not seeking to file a claimwith their group health plan, health insurance coverage, or FEHB health benefits plan (self-pay individuals), and health care provider, facility, or provider of air ambulance services by determining the amount such individual must pay to their health care provider, facility, or provider of air ambulance services. Under federal criteria, SDR entities will review initiation notices to determine that an uninsured (or self-pay) individual is eligible to dispute a bill.

Section 45 CFR 149.610(c), establishes requirements for the content that must be included in a good faith estimate that is issued to an uninsured (or self-pay) individual. Per 45 CFR 149.610(c)(1), all of the required elements must be included in the good faith estimate that the convening provider or convening facility issues to the uninsured (or self-pay) individual. As specified in 45 CFR 149.610(c)(1)(iii)(B), the good faith estimate information submitted by co-providers or co-facilities, as specified in 45 CFR 149.610(b)(2) and (c)(2) must also be included as part of the good faith estimate issued to the uninsured (or self-pay) individual.

The table below identifies data elements that health care providers and facilities, are required to include in the good faith estimate beginning on January 1, 2022. From January 1, 2022 through December 31, 2022, HHS will exercise its enforcement discretion in situations where the good faith estimate does not include expected charges for items and services from a co-provider or co-facility. These data elements must be provided by a co-provider or co-facility beginning January 1, 2023.

| DATA ELEMENT | DESCRIPTION |
|---|---|
| **Good Faith Estimate submitted by Convening Provider or Convening Facility** | |
| Name and date of birth of the uninsured (or self-pay) individual | First name, last name, and date of birth for the uninsured (or self-pay) individual receiving items or services. |
| Account Number (last four digits) (optional) | The number that is assigned to the patient in order to help the provider identify the patient, date(s) of service, and items and services. |

| DATA ELEMENT | DESCRIPTION |
|---|---|
| Description of the primary item or service in clear and understandable language (and if applicable, the date the primary item or service is scheduled) | A description of the item or service to be furnished by the convening provider or facility (as defined for purposes of 45 CFR 149.610) that is the initial reason for the visit. |
| Itemized list of items and services reasonably expected to be furnished for the primary item or service, and items or services reasonably expected to be furnished in conjunction with the primary item or service for the period of care | An itemized list of the items and services, grouped by each provider or facility, reasonably expected to be furnished to the uninsured (or self-pay) individual, reasonably expected to be provided for the primary item or service, and items and services expected to be furnished in conjunction with and in support of the primary item or service, for that period of care including: (1) those items and services expected to be furnished by the convening provider or facility, and (2) those items and services expected to be furnished by co-providers or co-facilities, for the period of care. |
| Service codes | Description of an item or service using the Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), Diagnosis-Related Group (DRG), or National Drug Code (NDC) codes. |
| Diagnosis codes (if required for the calculation of the GFE) | The code that describes an individual's disease, disorder, injury, and other related health conditions using the International Classification of Diseases (ICD) code set. |
| Expected charges | Expected charges associated with each listed item or service. |
| Names of providers and facilities | First name, last name, and title of providers. Facilities legal name as written on their business license. |
| State(s) and office or facility location(s) | Physical address, including street name and number, city, state, and zip code for all providers and facilities involved in the expected period of care. |
| Tax ID Number | Provider or facility's taxpayer identification number (TIN), employer identification number (EIN), or federal tax identification number (FTIN) issued by the Internal Revenue Service. |
| National Provider Identifier | Provider or facility's National Provider Identifier. |

| DATA ELEMENT | DESCRIPTION |
|---|---|
| List of items and services requiring separate scheduling | A list of items and services that the convening provider or convening facility anticipates will require separate scheduling and are expected to occur either prior to or following the expected period of care for the primary item or service. The good faith estimate must include a disclaimer directly above this list that states that separate good faith estimates will be issued to an uninsured (or self-pay) individual upon scheduling of the listed items and services; for items and services included in this list, information such as diagnosis codes, service codes, expected charges and provider or facility identifiers need not be included as that information will be provided in separate good faith estimates upon scheduling of such items and services. |
| Disclaimer stating that good faith estimate is an estimate and subject to change | Disclaimer informing the uninsured (or self-pay) individual that the information provided in the good faith estimate are estimates and not the final overall total charges. |
| Disclaimer stating that there may be additional items or services not contained in good faith estimate | Disclaimer informing the uninsured (or self-pay) individual that additional items and/or services that are not in the good faith estimate may be recommended by the convening provider as part of the course of care, that must be scheduled separately and are not reflected in the good faith estimate (such as rehabilitation therapies or other post treatment items or services) and information regarding how an uninsured (or self-pay) individual can obtain a good faith estimate for such items or services. |
| Disclaimer of their right to initiate the patient-provider dispute resolution process | Disclaimer providing the uninsured (or self-pay) individual of their right to initiate the patient-provider dispute resolution process if the actual billed charges from any provider or facility are $400 more than the expected charges from that provider or facility included in the good faith estimate. |
| Disclaimer that the good faith estimate is not a contract | Disclaimer stating that the good faith estimate is not a contract and does not require the uninsured (or self-pay) individual to obtain the items and services from any of the providers or facilities identified on the good faith estimate. |
| **Good Faith Estimate submitted by Co-Providers or Co-Facilities to Convening Providers or Convening Facilities** | |
| Name and date of birth of the uninsured (or self-pay) individual | First name, last name, and date of birth for the uninsured (or self-pay) individual receiving items or services. |

| DATA ELEMENT | DESCRIPTION |
|---|---|
| Itemized list of items and services expected to be furnished by co-provider or co-facility | Itemized list of items or services that are reasonably expected to be furnished in conjunction with the primary item or service for the period of care. |
| Service codes | Description of an item or service using the CPT code, HCPCS, DRG, or NDC codes. |
| Diagnosis codes (if required for the calculation of the GFE) | The code that describes an individual's disease, disorder, injury, and other related health conditions using the ICD code set. |
| Expected charges | Expected charges associated with each listed item or service. |
| Names of co-providers and co-facilities | First name, last name, and title of co-providers. Co-facilities legal name as written on their business license. |
| Tax ID Number | Provider or facility's TIN, EIN, or FTIN issued by the Internal Revenue Service. |
| National Provider Identifier | Provider or facility's National Provider Identifier. |
| State(s) and office or facility location(s) | Physical address, including street name and number, city, state, and zip code. |
| Disclaimer that the good faith estimate is not a contract | Disclaimer stating that the good faith estimate is not a contract and does not require the uninsured (or self-pay) individual to obtain the items and services from any of the providers or facilities identified on the good faith estimate. |

**Paperwork Reduction Act Statement**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 1210-0169. The time required to complete this information collection is estimated to average of 2 hours per respondent, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

**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.