OMB Control Number: 0938-1433
Expiration Date: 11/2025

Appendix 2

Standard Form: "Good Faith Estimate for Health Care Items and Services" Under the No Surprises Act

(For use by health care providers, facilities, and providers of air ambulance services no later than January 1, 2022)

Instructions

Under Section 2799B-6 of the Public Health Service Act and its implementing regulations, health care providers, health care facilities, and providers of air ambulance services are required to provide a good faith estimate of expected charges for items and services to 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 not seeking to file a claim with their group health plan, health insurance coverage, or FEHB health benefits plan (self-pay individuals) **in writing** (and may also provide it orally, if an uninsured (or self-pay) individual requests a good faith estimate in a method other than paper or electronically), upon request **or** at the time of scheduling health care items and services. For ease of reference, for purposes of this document, the term "provider" should be considered to include providers of air ambulance services.

This form may be used by the health care providers and facilities to inform uninsured (or self-pay) individuals of the expected charges 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 at least 3 business days; and within 3 business days of scheduling an item or service to be provided in at least 10 business days.

To use this model notice, the provider or facility must determine whether the circumstances require the use of the standard good faith estimate form or permit use of the abbreviated (no cost) good faith estimate form, then fill in the blanks with the appropriate information on the appropriate form. 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, a good faith estimate that meets all of the requirements under 45 CFR 149.610, is necessary in order 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, or formal 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 HHS interim final rules (IFR) titled *Requirements Related to Surprise Billing; Part II*, published on October 7, 2021 (86 FR 55980).

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

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 0938-1433. The time required to complete this information collection is estimated to average 1.3 hours per response, 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.

[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			

Date of Good Faith Estimate: _____/_____/_____	
Summary of Expected Charges (See the itemized estimate attached for more detail.)	
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[S] OF SERVICE, IF SCHEDULED] [[ADD IF ADDITIONAL ITEMS/SERVICES ARE BEING INCLUDED], as well as for items or services reasonably expected to be furnished in conjunction with the primary item or service as part of the period of care]. [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 (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					

[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 (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 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 3]

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 3] $					
Additional Health Care Provider/Facility Notes					

Total estimated cost for all services and items: $

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]

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.

Abbreviated GFE for No-Cost Health Care Items or Services

This abbreviated GFE should **only** be used by a provider or facility that **does not expect to bill the uninsured (or self-pay) individual** for items or services furnished on the date the items or services are expected to be provided.

[*insert* NAME OF PROVIDER OR FACILITY]
Good Faith Estimate for No-Cost Health Care Items & Services

This provider/facility will not bill you for items or services scheduled to be provided on [*insert date(s)*] **[*If items or services have not been scheduled, replace with this:* This provider/facility will not bill you for items or services.]**		
Patient Name:	Patient Date of Birth:	
Patient Identifier (optional):		
Provider/Facility Name:		
Provider/Facility Street Address (where items or services are expected to be furnished):		
City:	State:	ZIP Code:
Provider/Facility Contact:	Phone:	
Email Address:		
National Provider Identifier (NPI):	Taxpayer Identification Number (TIN):	
Date of Good Faith Estimate:		

Disclaimer

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.

There may be additional items or services the convening provider or convening facility recommends as part of the course of care that must be scheduled or requested separately.

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.

If you do receive a bill that is $400 or more, 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. The initiation of this process will not adversely affect the quality of health care services furnished to an uninsured (or self-pay) individual by a provider or facility.

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.

For questions or more information about your right to a Good Faith Estimate, the dispute resolution process, or to get a form to start the dispute resolution 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 by the provider or facility.

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.