Good Faith Estimate for Health Care Items and Services

Patient First Name	Middle Name	Last Name
Patient Date of Birth:		
Patient Address:		
City:	State:	ZIP Code:
Phone:	Cell :	
Email Address:		
Primary Service Description and		Primary Service CPT
Patient Primary Diagnosis		Primary Diagnosis Code
Patient Secondary Diagnosis		Secondary Diagnosis Code
If scheduled, list the Date of Service: [ ] Check this box if this service or item is not yet scheduled		
Lighthouse Surgery Center	Estimated Total Cost	
Provider/Surgeon	Estimated Total Cost	
Woodland Anesthesia	Estimated Total Cost	
Date:	**Total Estimated Cost:$**	

Lighthouse Surgery Center Detail of Services

Service/Item	Address where service/itemwill be provided	Diagnosis Code	Service Code	Quantity	Expected Cost
	129 Woodland Street, Hartford, CT 06105				
	129 Woodland Street, Hartford, CT 06105				
	129 Woodland Street, Hartford, CT 06105				
	129 Woodland Street, Hartford, CT 06105				

Total Expected Charges from Lighthouse Surgery Center	**$**

Woodland Anesthesia Detail of Services

Service/Item	Address where service/itemwill be provided	Diagnosis Code	Service Code	Quantity	Expected Cost
	129 Woodland Street, Hartford, CT 06105				

Total Expected Charges from Woodland Anesthesia	**$**

Surgeon Detail of Services

Service/Item	Address where service/itemwill be provided	Diagnosis Code	Service Code	Quantity	Expected Cost
	129 Woodland Street Hartford, CT 06105				

Total Expected Charges from Surgeon	**$**

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 askif 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/consumers or call 1-800-985-3059.

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

Keep a copy of this Good Faith Estimate in a safe place or take a picture of it. You may need it if you are billed a higher amount.