Orthopaedic Specialty Group, PC

Good Faith Estimate for Health Care Items and Services

Patient

First Name **Middle Name** **Last Name**

Date of Birth:

Patient Identification Number:

Patient Mailing Address, Phone Number, and Email Address

Street or PO Box

City **State** **Zip**

Phone

Email Address

Patient Diagnosis

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:

Provider Name **Estimated Total Cost**

Total Estimated Cost: **$** **(If paid in full at time of service: $)**

[Provider/Facility] Estimate

Provider/Facility Name **Provider/Facility Type**

Street Address **Phone**

City **State** **ZIP Code**

National Provider Identifier **Taxpayer Identification Number**

Details of Services and Items for [Provider/Facility]

Service/Item	Address for service/item	Diagnosis Code	Service Code	Quantity	Expected Cost	Discounted Rate*
Total Expected Charges from [Provider/Facility]					**$**	**$**

Additional Health Care Provider/Facility Notes

Total estimated cost for all services and items: $ (Discount rate: $)

*Discounted rate only applies if payment for services is paid in full at the time of service.

There may be additional items or services the convening provider recommends as part of the course of care that must be scheduled or requested separately and are not reflected in the good faith estimate.

The information provided in this good faith estimate is only an estimate regarding items or services reasonably expected to be furnished at the time the good faith estimate is issued. Actual items, services, or charges may differ from the good faith estimate.

The good faith estimate is not a contract and does not require you to obtain the items or services from any of the providers or facilities identified in the good faith estimate.

If the actual billed charges are substantially in excess of the expected charges included in this good faith estimate, as specified in § 149.620, you have the right to initiate the patient-provider dispute resolution process. See https://www.cms.gov/nosurprises/consumers/payment-disagreements for information on how to initiate this process. The initiation of the patient-provider dispute resolution process will not adversely affect the quality of health care services furnished to you by OSG providers.