You have the right to receive a “Good Faith Estimate” explaining how much your medical care will cost

Under the law, health care providers need to give patients who don’t have certain types of health care coverage or who are not using certain types of health care coverage an estimate of their bill for healthcare items and services before those items or services are provided.

- You have the right to receive a Good Faith Estimate for the total expected cost of any healthcare items or services upon request or when scheduling such items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- If you schedule a health care item or service at least 3 business days in advance, make sure your health care provider or facility gives you a Good Faith Estimate in writing within 1 business day after scheduling. If you schedule a health care item or service at least 10 business days in advance, make sure your health care provider or facility gives you a Good Faith Estimate in writing within 3 business days after scheduling. You can also ask any health care provider or facility for a Good Faith Estimate before you schedule an item or service. If you do, make sure the health care provider or facility gives you a Good Faith Estimate in writing within 3 business days after you ask.
- The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. Your bill could be more than the Good Faith Estimate if complications or special circumstances occur. If you receive a bill that does NOT include unknown or unexpected costs or costs related to complications or special circumstances, and it is at least $400 more for any provider or facility than your Good Faith Estimate from that provider or facility, you can dispute the bill.

For questions or more information about your right to a Good Faith Estimate, visit cms.gov/nosurprises/consumers, email FederalPPDRQuestions@cms.hhs.gov, call 1-800-985-3059, or call UCHealth Patient Estimates at 877.349.8520.

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.

My signature acknowledges receiving this notice and does not waive my rights under the law.

Name of patient (printed) ____________________________ Relationship to patient ____________________________

Signature of patient or legally authorized representative ____________________________

Date ____________________________ Time ____________________________

CERTIFICATION OF INTERPRETER SERVICES (if the patient’s preferred language for health care is not English).

I have communicated the information on this form and any explanations to the patient using a Qualified Medical Interpreter in the patient’s preferred language, or by speaking to the patient as a Qualified Bilingual Provider.

Interpreter name or number ____________________________: Qualified Medical Interpreter ☐ Yes ☐ No

Qualified Bilingual Provider ☐ Yes ☐ No