Good Faith Estimate for Mental Health Services

No Surprises Act - for use by mental health providers no later than January 1, 2022

Instructions

Under Section 2799B-6 of the Public Health Service Act, mental health providers are required to provide a good faith estimate of expected charges for services to clients who are not enrolled in a plan, coverage, or federal health care program, or not seeking to file a claim with their plan or coverage both orally and in writing, upon request or at the time of scheduling mental health services.

This form may be used by the mental health providers to inform uninsured or self-pay clients of the expected charges they may be billed for receiving certain services. A Good Faith Estimate must be provided **within 3 business days**. Information regarding services must be furnished **within 1 business day** of scheduling a service to be provided in 3 business days, and **within 3 business days** of scheduling a service to be provided in at least 10 business days.

Fill in the form with the appropriate information. The use of this form allows you to be in compliance with the Good Faith Estimate requirements.

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[Name, Address, Logo, Agency, or Clinic]

Good Faith Estimate for Mental Health Services

Client Name: ____ Date of Birth: __________________

Client Identification Number: ________________________________

Mailing Address: ____

Phone Number: (   ) _______________ Email Address: ____

Client's Contact Preference: [ ] By USPS mail [ ] By email [ ] By text

Service Scheduled: ____

Primary Diagnosis: ________________________________ Primary Diagnosis Code: ___________________

Secondary Diagnosis: ______________________________ Secondary Diagnosis Code: ________________

If scheduled, list the date(s) the service will be provided:
[ ] *Check here if this service is not yet scheduled*

Date of Good Faith Estimate: ___________/___________/___________

Summary of Expected Charges

Clinician Name: __________________________________ Estimated Total Cost: ____________________

Clinician Name: __________________________________ Estimated Total Cost: ____________________

Clinician Name: __________________________________ Estimated Total Cost: ____________________

Total Estimated Cost: $_______________

The following is a detailed list of expected charges for _____________________ [*primary service*], scheduled for _________________ [*date of service, if scheduled*]. ***Note if services are reoccurring***.

The estimated costs are valid for ______ months from the date of this Good Faith Estimate.

[Provider/Facility #1] Estimate

Name:	Type:
Address:	City/State/Zip:
Contact Person:	Phone:
Email:	NPI:

Details of Services

Service	Address where service will be provided	Diagnosis Code	Service Code	Quantity	Expected Cost

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Total Expected Charges from [Provider/Facility #1] Estimate: $__________________

Notes:

[Provider/Facility #2] Estimate [*delete this section if unnecessary*]

Name:	Type:
Address:	City/State/Zip:
Contact Person:	Phone:
Email:	NPI:

Details of Services

Service	Address where service will be provided	Diagnosis Code	Service Code	Quantity	Expected Cost

Total Expected Charges from [Provider/Facility #2] Estimate: $__________________

Notes:

[Provider/Facility #3] Estimate [*delete this section if unnecessary*]

Name:	Type:
Address:	City/State/Zip:
Contact Person:	Phone:
Email:	NPI:

Details of Services

Service	Address where service will be provided	Diagnosis Code	Service Code	Quantity	Expected Cost

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Total Expected Charges from [Provider/Facility #3] Estimate: $__________________

Notes:

Clinician Name: ____ Date: _________________________

Signature: ____

Disclaimer: This Good Faith Estimate shows the costs of services that are reasonably expected for your mental health care. The estimate is based on information known at the time the estimate was created. This 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 estimate, you have the right to dispute the bill. You may contact the provider or facility listed on this form to let them know the billed charges are higher than the estimate. You can ask them to update the bill to match the 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 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 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. For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises. 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.

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