**Good Faith Estimate for Health Care Items and Services Co-Provider Requests  
  
(For use by health care providers no later than January 1, 2022)**

**Instructions**

The federal No Surprises Act and Indiana law impose new requirements on providers to give patients Good Faith Estimates of health care charges both upon request **and** upon scheduling a health care service, and for uninsured or self-pay patients, upon scheduling a health care service. This Good Faith Estimate requirement becomes mandatory, regardless of whether a patient requests one, beginning January 1, 2022 under Indiana law and the No Surprises Act.

These laws require the health care facility or provider receiving the request or scheduling the primary item or service (“Convening Provider”) to include information from providers who may provide items or services in conjunction with the primary item or service (“Co-Provider”).

**Requirements for Co-Providers**

Co-Providers must:

* Submit good faith information upon request of the Convening Provider no later than 1 business day after receiving the request from the Convening Provider.
* Notify and provide new Good Faith Estimate information if the Co-Provider anticipates any changes to the scope of the Good Faith Estimate information previously submitted (i.e., anticipated changes to expected charges, items, services, frequency, recurrences, duration, providers, or facilities).
* In the case of a replacement Co-Provider, the replacement Co-Provider must accept as its Good Faith Estimate the original Good Faith Estimate if the changes occurred less than 1 business day before the item or service is scheduled to be provided.

**Good Faith Estimate Contents**

The information that a Co-Provider must submit for inclusion in the Good Faith Estimate, an example of which is included below.

**[NAME OF CONVENING PROVIDER OR CONVENING FACILITY]**

# Request for Good Faith Estimate Information

# Date:\_\_\_\_\_\_\_\_\_\_, 2022

# Name and Address

# RE: Request for Good Faith Estimate

# *[Patient name]*

# *[Scheduled Service and Date of Service]*

# Dear \_\_\_\_\_\_\_\_\_\_\_\_\_,

# You have been identified as a provider who is expected to furnish items or services in conjunction with our patient’s primary item or services described above as part of their period of care. As such, we are obligated to include your cost information in our Good Faith Estimate. Under state and federal law, you must complete and return the information in Attachment A within one (1) business day of the date of this notice. We appreciate your cooperation.

# Please return this completed form, and direct any future correspondence regarding this form, to:

# *[Name*

# *Title*

# *Organization Name*

# *Address*

# *Phone*

# *Email]*

# You understand that are under a continuing legal obligation to update the information you provide if you reasonably anticipate any changes to the scope of the information you provide. Such changes may include changes to the expected charges, items, services, frequency, duration, providers, or facilities. We are under no legal obligation to create a Good Faith Estimate for items or services that a patient must separately schedule with you.

Sincerely,

**Name**

**Title**

**Attachment A**

**Co-Provider Good Faith Estimate**

|  |  |  |
| --- | --- | --- |
| **Patient** | | |
| Patient First Name | Middle Name | Last Name |
| Patient Date of Birth: / / | | |

# Co-Provider/Facility 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 Co-Provider/Facility**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Service/Item | Address where service/item will be provided | Diagnosis Code | Service Code | Quantity | Expected Cost |
|  | [Street, City, State, ZIP] | [ICD code] | [Service Code Type: Service Code Number] |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

|  |
| --- |
| Additional Health Care Provider/Facility Notes |

|  |
| --- |
| **Total estimated cost for all services and items: $** |

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