**TEMPLATE**

**Good Faith Estimate for Health Care Items and Services

(For use by health care providers no later than January 1, 2022)**

**Instructions**

The federal No Surprises Act and Indiana law require health care providers and facilities to give patients Good Faith Estimates of health care charges both upon request **and** upon scheduling a health care service. For uninsured and self-pay patients, 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. A decision tree showing the potential outcomes for giving a Good Faith Estimate is included as Attachment A.

**Insured and Uninsured Patients**

Indiana’s attempts to align its Good Faith Estimate law with the No Surprises Act has created some confusion due to decisions by Federal regulators to delay certain requirements. Indiana currently requires providers to give a Good Faith Estimate to patients only upon request, whereas the No Surprises Act requires providers to give a Good Faith Estimate regardless of a request upon scheduling a nonemergency health care service. However, Federal regulators recently decided to delay the Good Faith Estimate requirement as to insured patients due to logistical issues. Thus, after January 1, 2022, providers must give a Good Faith Estimate to uninsured patients and self-pay patients. Insured patients should receive a Good Faith Estimate only when requested until rulemaking is finalized.

The following table represents a provider’s requirements starting January 1, 2022.

|  |  |
| --- | --- |
| **When Requested** | **Mandatory Upon Scheduling**  |
| * Uninsured patient
* Self-pay patient
* Insured patient
 | * Uninsured patient
* Self-pay
* Insured patient
 |

**Good Faith Estimate Contents**

In general, Good Faith Estimates must include the charge for the nonemergency health care service by those who are involved in the episode of care and a legal notice for patients regarding the Good Faith Estimate. The laws define specific categories that must be included in the Good Faith Estimate to support the total charges, which are included in a Good Faith Estimate form in Attachment B.

**Convening Facilities and Co-Providers**

The provider giving a Good Faith Estimate must include the charges of other outside entities or providers involved in the episode of care. The provider who schedules the service (“Convening Facility”) is responsible for compiling and providing the Good Faith Estimate. Other providers involved in the episode of care (“Co-Providers”) must provide cost and charge information to the Convening Facility to include

in the Good Faith Estimate, when applicable.

**Timing**

|  |  |  |
| --- | --- | --- |
| **Patient Status (Scheduling)** | **Days before providing the item or service** | **Days to provide notice after scheduling**  |
| **Uninsured or Self-Pay** | 10 or more days | At least 3 business days |
| Between 3 and 10 days | At least 1 business day |
| Less than 3 days | No Good Faith Estimate required |
| **Insured**  | N/A | N/A |
|  |
| **Patient Status (Request)** | **Days after receiving a request** | **Notes** |
| **Uninsured or Self-Pay** | Not later than 3 business days  | Per Federal law |
| **Insured** | Not later than 5 business days  | Per Indiana law |

**Scope of Services**

Convening Providers must identify those items or services reasonably expected to be furnished for the primary item or service, and items or services reasonably expected to be furnished in conjunction with the primary items or service for that period of care. Such care many include items and services reasonably expected to be provided by Co-Providers for that period of care.

*Period of Care*

A “period of care” means the day or multiple days during which the good faith estimate for scheduled or requested item or service (or set of scheduled or requested items or services) are furnished or are anticipated to be furnished, regardless of whether the convening provider, convening facility, co-providers, or co-facilities are furnishing such items or services, and also includes the period of time during which any facility equipment and devices, telemedicine services, imaging services, laboratory services, and preoperative and postoperative services that would not be scheduled separately by the individual, are furnished. If an item or service is to be separately scheduled, then a Good Faith Estimate would need to be issued for those items or services at that time.

*Scheduled Services*

A Good Faith Estimate must be given to an uninsured or self-pay individual upon scheduling an “item or service.” CMS defines “items or services” by referencing 45 CFR 147.210(a)(2), which includes all encounters, procedures, medical tests, supplies, prescription drugs, durable medical equipment, and fees (including facility fees), provided or assessed in connection with the provision of health care.

Some services may not be included in a good faith estimate because they are not typically scheduled in advance and are not typically the subject of a requested good faith estimate, e.g., (urgent emergent trauma, or emergency items or services). However, to the extent an urgent care appointment is scheduled at least 3 days in advance, these interim final rules require a provider or facility to provide a good faith estimate.

*Recurring Services*

A single Good Faith Estimate may be used for recurring services like multiple therapy visits. In such cases, the Good Faith Estimate must include the expected scope of recurring services (i.e., timeframes, frequency, and total number of recurring items or services) and the estimate cannot exceed 12 months.

*Rates*

The method for calculating good faith estimates differs depending on whether the patient is insured or uninsured. A Good Faith Estimate provided to an insured patient upon request is required to be based on the **negotiated price** the provider and/or facility has agreed to as an in-network provider with respect to the patient’s health plan.

Uninsured patients receiving an estimate upon request or upon the scheduling of a service must be provided with the amount they will be charged as an uninsured patient, i.e., **usual and customary charge**. This is oftentimes the standard charge for a particular service, although some providers may apply a self-pay discount.

**Forms**

The Centers for Medicare and Medicaid Services (“CMS”) published model notices for providers to use for their Good Faith Estimates and using such forms is considered good faith compliance with the Good Faith Estimate requirements. Additionally, some form of notice, including the provision of certain required information, is necessary to begin the patient-provider dispute resolution process. Attachment B is based off the CMS model notice, CMS’s instructions, and has been modified to align with Indiana’s Good Faith Estimate laws.

**Disclaimer**

The information provided herein is intended only to be a general informal summary of technical legal standards. It is not intended to take the place of the statutes, regulations, or formal policy guidance upon which it is based. These instructions and any model notices summarize current regulations and guidance and may be subject to change. Health care providers should to refer to the applicable statutes, regulations, and appropriate interpretive materials for complete and current information, including CMS’s website at <https://www.cms.gov/nosurprises> and CMS forms and instructions <https://www.cms.gov/regulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10791>.

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 **Attachment A - Decision Tree
\*\*Until rulemaking for insured patients is completed.\*\***

10+ = at least 3 business days

Usual and customary charge

At least 3 up to 10 = 1 business day

>3 = No notice required

Provide GFE within 3 business days of the request

Days before procedure (if scheduled)

Verbal and written notice of patient rights

Provide GFE within 5 business days of the request (negotiated rate)

Yes

No

Uninsured/Self Pay

Insured Patient

Patient

Schedules an item or service

**Attachment B - Based off the CMS Forms**

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

# Good Faith Estimate for Health Care Items and Services

|  |
| --- |
| **Patient** |
| Patient First Name | Middle Name | Last Name |
| Patient Date of Birth: / /  |
| Patient Identification Number: |
| **Patient Mailing Address, Phone Number, and Email Address** |
| Street or PO Box |  | Apartment |
| City | State | ZIP Code |
| Phone |
| Email Address |
| Patient’s Contact Preference: | [ ] By mail | [ ] By email |
| **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 |
| Provider Name | Estimated Total Cost |
| Provider Name | Estimated Total Cost |
| **Total Estimated Cost: $** |

(See the itemized estimate attached for more detail.)

**Summary of Expected Charges**

The following is a detailed list of expected charges for [LIST PRIMARY SERVICE OR ITEM], scheduled for [LIST DATE OF SERVICE, IF SCHEDULED].

**\*Drafting Note**: the scope of a good faith estimate for recurring primary items or services cannot exceed 12 months. If such services or items are expected to exceed 12 months, the provider must give a new Good Faith Estimate after 12 months and communicate any changes to help the patient understand what has changed between these Good Faith Estimates. Such changes may include timeframes, frequency, and total number of recurring items or services. If services are recurring, including the following statement: “The estimated costs are valid for 12 months from the date of the Good Faith Estimate.”]

 **\*\*Drafting Note:** The description of the service must be written in clear and understandable language.

# [Provider/Facility 1] 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 [Provider/Facility 1]**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 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] |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

|  |
| --- |
| **Total Expected Charges from [Provider/Facility 1] $** |
| Additional Health Care Provider/Facility Notes |

|  |
| --- |
| 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 [Provider/Facility 1] That Require Separate Scheduling**

***Disclaimer: The services and items below must be separately scheduled and are not included in this Good Faith Estimate. You will be issued separate Good Faith Estimates for these items and services upon scheduling in accordance with the law.***

|  |  |
| --- | --- |
| Service/Item | Occurrence  |
|  |  [prior to or following the expected period of care] |
|  |  |
|  |  |

**\* Drafting Note**: An itemized list of the items and services must include those items and services reasonably expected to be furnished to the uninsured (or self-pay) individual, reasonably expected to be provided for the primary item or service, and items and services expected to be furnished in conjunction with and in support of the primary item or service, for that period of care including: (1) those items and services expected to be furnished by the convening provider or facility, and (2) those items and services expected to be furnished by co-providers or co-facilities, for the period of care as noted below.

**\*\* Drafting Note**: There may be items and services that the convening provider or convening facility anticipates will require separate scheduling and are expected to occur either prior to or following the expected period of care for the primary item or service. For such items and services, separate good faith estimates will be issued to an uninsured (or self-pay) individual upon scheduling of the listed items and services; for items and services included in this list, information such as diagnosis codes, service codes, expected charges and provider or facility identifiers need not be included as that information will be provided in separate good faith estimates upon scheduling of such items and services.

# \*\*Drafting Note: include the following when another facility (or Co-Provider) is assisting with the scheduled item or service. The Co-Provider must provide this information within 1 business day of the receiving the request. If a Convening Provider must submit the Good Faith Estimate to the patient before receiving information from Co-Providers, the Convening Provider should update and correct the Good Faith Estimate as soon as possible to avoid regulatory violations.

**Details of Services and Items for [Provider/Facility 2] DELETE IF NOT NEEDED**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 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] |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

|  |
| --- |
| **Total Expected Charges from [Provider/Facility 2] $** |
| Additional Health Care Provider/Facility Notes |

# [Provider/Facility 3] Estimate [Delete if not needed]

|  |
| --- |
| 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 [Provider/Facility 3]**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 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] |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

|  |
| --- |
| **Total Expected Charges from [Provider/Facility 3]$** |

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

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

# Disclaimer

The intended charges set forth in the Good Faith Estimate is provided in good faith and is our best estimate of the amount we will charge for the items and services that are reasonably expected for your health care needs. Additional items or services that are recommended as part of your course of care that must be scheduled or requested separately are not reflected in this Good Faith Estimate. A separate Good Faith Estimate will be issued for such items or services upon scheduling.

The Good Faith Estimate is based on information known at the time the estimate was created. This estimate is not a contract, is non-binding, and is valid only for thirty (30) days. Your receipt of this Good Faith Estimate does not obligate you to receive items or services from us and/or those entities listed in the Good Faith Estimate.

The estimate does not include any unknown or unexpected costs that may arise during treatment. Therefore, the actual price of your health care services may vary from the estimate based on your medical needs.

**Rights of Uninsured or Self-Pay Patients to Dispute Charges**

# This section applies if you are uninsured or self-pay (not submitting charges to your health plan). You have a right to dispute their bill if the actual charges substantially exceed the amount of the Good Faith Estimate. An amount “substantially exceeds” the Good Faith Estimate when the total charges are at least $400 more than the expected charges in the Good Faith Estimate.

# If your final bill substantially exceeds the Good Faith Estimate, you (or your authorized representative) may dispute (or appeal) your bill through the dispute resolution process with the U.S. Department of Health and Human Services (HHS) as follows:

# Start the dispute process by submitting notification to HHS within 120 calendar days (about 4 months) of the date on the original bill that is substantially in excess of the Good Faith Estimate.

# Pay a $25 fee.

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.

You may also contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You may request that they update the bill to match the Good Faith Estimate, seek to negotiate the bill, or ask whether financial assistance is available.

For questions or more information about your rights under the law, the dispute process, or to obtain forms to initiate a dispute, go to [www.cms.gov/nosurprises](http://www.cms.gov/nosurprises) or call 1-800-985-3059 for more information.

Keep a copy of this Good Faith Estimate in a safe place.