Request for Good-Faith Estimate of Charges

University Community Hospital
UNIVERSITY COMMUNITY HEALTH

Please complete Section 1 and return form to the Hospital at the address below

SECTION 1:

Name:____

Address:____

City:___________________, State:____________ ZIP:_______

Telephone Number:___________________________________

I am requesting that University Community Hospital provide me a good-faith estimate of charges for the procedure(s) listed below. I understand that this is only an estimate of charges based on the information that I am providing and based on the Hospital's average charges for these services. Actual charges may be higher based on several factors including the services I ultimately receive and my final length of stay.

Please provide the following information. What type of services will you be receiving?

❑ Inpatient ❑ Outpatient Surgery ❑ Outpatient Testing

Please describe the services you will be receiving. Be as specific as possible – include surgical procedures and diagnostic tests if applicable. You will be sent a written response to the address above within seven (7) business days of our receipt of your completed form.

SECTION 2: TO BE COMPLETED BY A HOSPITAL REPRESENTATIVE

Date Received:____________________

Inpatient: Based on the information you have provided above, we estimate that your services will be classified as a DRG _____. The Average Charge for this DRG is $_____________ for an average length of stay of ___________ days. This estimate is based on the average services a patient with this DRG receives during the average length of stay. Your actual charges may be higher if your length of stay is longer than the average noted above. Note: When implantable devices are used in surgical procedures, charges vary depending on the actual cost of the implantable device.

Outpatient Surgery: Based on the information you have provided above, we estimate that the average total charges will be $________________. Actual charges may vary based on additional services that may be determined to be medically necessary by your physician. Note: When implantable devices are used in surgical procedures, charges vary depending on the actual cost of the implantable device.

Outpatient Diagnostic Services: We estimate that your charges for the procedures you have listed above will be $_____________. Your actual charges may vary if you receive additional services beyond those listed above.

_______________________________________ ____________________________

Hospital Representative Date