

# Request for Good-Faith Estimate of Charges

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 or telephone request.


## SECTION 2: TO BE COMPLETED BY A HOSPITAL REPRESENTATIVE

Date Received: \_\_\_\_\_

**Inpatient:** Based on the information you have provided above, we estimate the average total charges for your admission will be \$\_\_\_\_\_, with an average length of stay of \_\_\_\_ days. Actual charges may vary based on additional services that may be determined to be medically necessary by your physician or a length of stay longer than 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