

ELEVATION PHYSICAL THERAPY & SPORTS REHAB LLC

Good Faith Estimate for Health Care Items and Services

Date of Good Faith Estimate:

Patient Information		
Patient First Name	Middle Name	Last Name
Patient Date of Birth:		
Patient Identification Number:		
Address:		
Street or PO Box:		Apartment No:
City:	State:	Zip Code:
Phone:		
Email Address:		
Patient Contact Preference (circle one):		
By mail	By email	By phone

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:	
<input type="checkbox"/> Check this box if this service of item is not yet scheduled	

Summary of Expected Charges (See the itemized estimate attached for more detail)	
Provider Name:	Estimated Total Cost:
Total Estimated Cost:	

The following is a detailed list of expected charges for Physical Therapy Services, scheduled for [List Dates of Services, if scheduled] [[and Add if additional items/services are being included], as well as for items or services reasonably expected to be furnished in conjunction with the primary item or service as part of the period of care]. [Include if items or services are reoccurring, “The estimated costs are valid for 12 months from the date of the Good Faith Estimate.”]

PROVIDER ESTIMATE

Provider Name:		Provider Type:	
Street Address:			
City:	State:	Zip Code:	
Contact Person:	Phone	Email:	
National Provider Identifier:		Taxpayer Identification Number:	

Details of Services and Items for Provider					
Service/Item	Address where service/item will be provided	Diagnosis Code	Service Code	Quantity	Expected Cost
Total Expected Charges from Provider:				\$	
Additional Health Care Provider Notes:					

DISCLAIMER:

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created.

The Good Faith 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, and your bill is \$400 or more for any provider or facility than your Good Faith Estimate for that provider or facility, federal law allows you to dispute the bill.

If you are billed more than this Good Faith Estimate, you may have the right to dispute the bill.

You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith 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 (about 4 months) of the date on the original bill.

If you dispute your bill, the provider or facility cannot move the bill for the disputed item or service into collection or threaten to do so, or if the bill has already moved into collection, the provider or facility has to cease collection efforts. The provider or facility must also suspend the accrual of any late fees on unpaid bill amounts until after the dispute resolution process has concluded. The provider or facility cannot take or threaten to take any retributive action against you for disputing your bill.

There is a \$25 fee to use the dispute process. If the Selected Dispute Resolution (SDR) entity reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate, reduced by the \$25 fee. If the SDR entity disagrees with you and agrees with the health care 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/consumers or call 1-800-985-3059.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises/consumers, email FederalPPDRQuestions@cms.hhs.gov, or call 1-800-985-3059.

<p>Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.</p>

PRIVACY ACT STATEMENT: CMS is authorized to collect the information on this form and any supporting documentation under section 2799B-7 of the Public Health Service Act, as added by Section 112 of the No Surprises Act, title I of Division BB of the Consolidated Appropriations Act, 2021 (Pub. L. 116-260). We need the information on the form to process your request to initiate a payment dispute, verify the eligibility of your dispute for the PPDR process, and to determine whether any conflict of interest exists with the independent dispute resolution entity selected to decide your dispute. The information may also be used to: (1) support a decision on your dispute; (2) support the ongoing operation and oversight of the PPDR program; (3) evaluate selected IDR entity's compliance with program rules. Providing the requested information is voluntary. But failing to provide it may delay or prevent processing of your dispute, or it could cause your dispute to be decided in favor of the provider or facility.