Erie County Community Health Center Tax ID# 346400428

Good Faith Estimate

On _____, , DOB: :

___ scheduled an appointment for

___ requested a Good Faith Estimate for the following services:

As of today:
_____ your diagnosis code(s) are: See below and they estimate your bill after the nominal fee to be:_____
_____ECCHC does not yet know the correct diagnosis codes for your visit.

I have checked below the services we expect you will receive during your visit. You should expect to be charge the amount listed below.

	Service	Code	Charge	% of Discount	Charge after Discount	Nominal fee
	Periodic Oral Eval	D0120	$56			
	Limited Oral Eval	D0140	$80			
	Comp Oral Eval/New/Est Patient	D0150	$80			
	Comprehensive Perio Eval	D0180	$80			
	Intraoral-Periapical 1 film	D0220	$40			
	Intraoral-Peripical-each additional	D0230	$20			
	Bitewing-Single Film	D0270	$40			
	Bitewing-2 films	D0272	$48			
	Bitewings Four Films	D0274	$80			
	Panoramic Film	D0330	$128			
	Prophylaxis Adult	D1110	$120			
	Prophylaxis Child	D1120	$80			
	Topical App of Flouride Varnish	D1208	$40			
	Sealant Per Tooth	D1351	$64			
	Resin One Surface;Anterior	D2330	$159			
	Resin Two Surfaces Anterior	D2331	$239			
	Resin Three Surfaces Anterior	D2332	$245			
	Resin 4+ W/Incis Angel Anterior	D2335	$319			
	Resin Composite 1s; Posterior	D2391	$175			
	Resin Composite 2s; Posterior	D2392	$229			
	Resin Composite 3s; Posterior	D2393	$282			
	Resin Composite 4+s;Posterior	D2394	$455			
	Periodontal Maintenace	D4910	$160			
	scaling in the presence of gingivitis	D4346	$718			

	Service	Code	Charge	% of Discount	Charge After Discount	Nominal fee
	Perio Scale & Root Plan4+Per Quad	D4341	$399			
	Perio Scale & Root Plan 1-3 Teeth	D4342	$216			
	Full Mouth Debridement	D4355	$200			
	Extract; Erupted Th/exposed Root	D7140	$176			
	Extraction Surgical/erupt Tooth	D7210	$319			
	Removal of Impacted Tooth Soft Tissue	D7220	$367			
	Removal of ImpactedTooth Partially Bony	D7230	$479			
	Full Bony	D7240	$190			
	FMX Intraoral-complete Series	D0210	$160			
		Total:				

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, federal law allows you to dispute (appeal) the bill.

Notified on: _____

ECCHC Employee Signature: _____

Patient/Guardian Signature:_____ Date of Signature:_____

If you are billed for more than this Good Faith Estimate, you 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. There is a $25 fee to use the dispute process. 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. 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 or call 1-800-985-3059. 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.