Request for Good Faith Estimate of Medical Services

To provide cost information for services not yet received, each of the providers and facilities associated with the service will need to give a "good faith" estimate of the services. As such, this estimate will be as accurate as the information provided on the form.

Instructions
To request information about the cost for proposed medical services, please complete as much information as possible in the form on the next page. Some of the information will come from your provider. If your service requires more than 1 provider, each provider will need to fill out the information related to the service they will provide. The accuracy of the estimate will depend on how accurate the information is on the form.

How to submit the form to us:

Please fill out the member information in Section 1 completely. Your provider should fill out or give you the complete information in Section 2 and 3 (if applicable).

- You can mail the form to: Fallon Health, Attn: Claims Department, 1 Mercantile St., Ste. 400, Worcester, MA 01608
- You can fax the form to: 1-508-368-9346
- You can scan and email the form to: ClaimEstimator@fallonhealth.org
  (I understand that information transmitted to and from me by email is unencrypted and as such is not secure. I understand that as a result, it may be possible for others to intercept the information sent and received.)

What we will send back to you:

We'll fill in the costs in this form and send it back to you in either an email or through the mail.
You can select the way you would like to receive it.

Important information about this estimate:

The cost estimates shown on this form are good faith estimates based on the information available to Fallon Health at the time the request was submitted. This includes, but is not limited to, information provided on this form to identify proposed services; member eligibility and enrollment status; dollar amounts accumulated towards deductibles and out of pocket maximums; and contract arrangements in place between the plan and network providers. If the proposed services shown on this form do not accurately reflect the services that are ultimately billed, or if any other information has changed between the time of the request and the time of service, the cost estimates shown on this form will no longer be valid. The cost estimates only reflect those services listed on the form and assume that the member has obtained any referral or authorization that may be required. The cost estimates also do not consider any unforeseen services that may arise out of proposed services. A member's financial responsibility may vary from the cost estimates provided should unforeseen services be received and billed. On an estimate for an inpatient service, Fallon Health will assume the patient will be discharged home. Note that for many types of services, there are typically separate charges from multiple providers. For example, there may be separate charges from facilities, anesthesiologists, or radiologists.

Questions? Need Help?
Call Customer Service at 1-800-868-5200 (TRS 711) or email us at cs@fallonhealth.org.

fallonhealth

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SECTION 1: MEMBER INFORMATION
Please fill out completely. We need all information to provide an estimate.

MEMBER NAME:	**PHONE NUMBER:** ( )
MEMBER NUMBER (on your member ID card):	**DATE OF BIRTH:**

ANTICIPATED SERVICE (tell us the procedure or service you would like the cost for):

PROVIDER NAME: **PROVIDER PHONE NUMBER:**

PROVIDER STATUS (Is the provider in your plan's network): ☐ In-network ☐ Out-of-network

Please sign here to give us permission to contact your provider about this service for accurate estimates.
SIGNATURE: **Date:**

Please check below how you would like to receive the cost estimate. You can have it emailed or sent through regular mail. Email will be delivered in 2 business days. Mail will be sent out in 2 business days to the mailing address we have on file. Mail delivery is dependent on the postal service.

☐ **Mail** ☐ **Email** **EMAIL ADDRESS (If preferred method):**

SECTION 2: PROVIDER INFORMATION (for professional charges – HCFA 1500 billing form)
Provider, please complete form as all fields are required to provide the member an accurate estimate. If no date is indicated, we will base the estimate on the date the estimate is processed.

PROVIDER NAME:	**PROVIDER NPI #:**
PAY-TO PROVIDER NAME:	**PAY-TO PROVIDER NPI #:**

	Provider to fill out or supply this information:								***Fallon Health completes:*** Estimate #: Call tracking #:		
	From date of service	**To date of service**	**Diagnosis code**	**POS**	**CPT/HCPCS/NDC**	**Modifier**	**Billed charge**	**Units**	**Allowed amount**	**YOUR COST**	**Notes**
1							**$**		**$**	**$**	
2							**$**		**$**	**$**	
3							**$**		**$**	**$**	
4							**$**		**$**	**$**	
5							**$**		**$**	**$**	

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SECTION 3: PROVIDER INFORMATION (for facility charges – UB-04 billing form)
Provider, please complete form as all fields are required to provide the member an accurate estimate. If no date is indicated, we will base the estimate on the date the estimate is processed.

PROVIDER NAME:	**PROVIDER NPI #:**
PAY-TO PROVIDER NAME:	**PAY-TO PROVIDER NPI #:**

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Provider to fill out or supply this information:

Fallon Health completes:
Estimate #:
Call tracking #:

From date of service	To date of service	Bill type	Admit date (if applies)	DRG (if applies)	Diag. codes	Revenue code	CPT/ HCPCS /NDC	Modifier	Units	Billed charge	Allowed amount	YOUR COST	Notes
										$	$	$	

2

Provider to fill out or supply this information:

Fallon Health completes:
Estimate #:
Call tracking #:

From date of service	To date of service	Bill type	Admit date (if applies)	DRG (if applies)	Diag. codes	Revenue code	CPT/ HCPCS /NDC	Modifier	Units	Billed charge	Allowed amount	YOUR COST	Notes
										$	$	$	

3

Provider to fill out or supply this information:

Fallon Health completes:
Estimate #:
Call tracking #:

From date of service	To date of service	Bill type	Admit date (if applies)	DRG (if applies)	Diag. codes	Revenue code	CPT/ HCPCS /NDC	Modifier	Units	Billed charge	Allowed amount	YOUR COST	Notes
										$	$	$	

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