Wabash General Hospital
People you know, helping people you love

1418 College Drive
Mount Carmel, IL 62863
www.wabashgeneral.com

Good Faith Estimate for Health Care Items and Services

Patient		
Patient First Name	Middle Name	Last Name
Patient Date of Birth: / /		
Patient Mailing Address, Phone Number, and Email Address		
Street or PO Box		Apartment
City	State	ZIP Code
Phone		
Email Address		
Patient's Contact Preference: [ ] By mail [ ] By email [ ] By patient portal		
Patient Diagnosis		
Primary Service or Item Requested/Scheduled		
Patient Primary Diagnosis		Primary Diagnosis Code
Patient Secondary Diagnosis		Secondary Diagnosis Code

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If scheduled, list the date(s) the Primary Service or Item will be provided: ____/____/____ Initial Service Date If a recurring service, estimated end date of service : ____/____/____ [ ] Check this box if this service or item is not yet scheduled
Date of Good Faith Estimate: ____/____/____
Provider Name Estimated Total Cost
Provider Name Estimated Total Cost

Total Estimated Cost (details provided on subsequent pages)	**$**_____
Hospital Prompt Pay discount (not applicable for Family Medical Center): If paid in full within 30 days of service or from first Hospital billing statement, prompt pay savings at _____**%** will apply and the total estimated balance you will owe is estimated at:	**$**_____
Financial Assistance discount _____ % If the patient has completed a prior financial assistance application and qualifies for a financial assistance discount, the discount will be applied and the estimated balance due entered on the total line.	**$**_____

If you have not applied for financial assistance and wish to do so, please contact our Financial Counselor at (618)263-6412 to apply. The Financial Assistance application can also be found at www.wabashgeneral.com. The following page(s) is a detailed list of expected charges for the primary service(s) and date(s) listed above.

If this is a recurring service, the estimated costs are valid for 6 months from the date of the Good Faith Estimate. Wabash General Hospital updates their charges typically every January 1st. As such, if you have services that will span before and after January 1st, please contact the Wabash General Hospital Financial Counselor (618)263-6412 in order to obtain an updated estimate on your out-of-pocket costs.

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Estimate of Charges by Wabash General Hospital

Facility Name, Type, Taxpayer Identifier Number (TIN) & National Provider Identifier (NPI) ☐ Wabash General Hospital - TIN 37-6013625 – NPI 1194728808
Address: 1418 College Drive, Mt. Carmel, IL 62863
Contact Person Phone Email

Details of Services and Items to be provided at 1418 College Drive, Mt. Carmel, IL 62863

Service/Item	Diagnosis Code	Service Code	Quantity	Expected Cost

Total Expected Charges $_____ (total from above)

Additional Health Care Provider/Facility Notes:

Reason for visit described by patient upon scheduling:

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Estimate of Charges from Separate Independent Providers

- ☐ Not applicable. No separate charges are expected.
- ☐ Separate professional fees are expected to be billed by the following provider.

Facility Name, Type, Taxpayer Identifier Number (TIN) & National Provider Identifier (NPI)		
Primary Office Address:		
Contact Person	Phone	Email

Details of charges billed separately by independent providers for Services to be provided at 1418 College Drive, Mt. Carmel, IL 62863

- ☐ **If charges are not listed below, an estimate from the independent provider could not be obtained before this good faith estimate was issued. We will continue to try and obtain an estimate that will be issued to you when available, but you are also welcomed to contact the office above to obtain more information about the charges this independent provider may bill for services provided.**

Service/Item	Diagnosis Code	Service Code	Quantity	Expected Cost

Total Expected Charges $_____ (total from above)

Additional Health Care Provider/Facility Notes:

Reason for visit described by patient upon scheduling:

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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.

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 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 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.

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Limited English Proficiency Notification
As required to meet compliance with the No Surprises Act

ATTENTION: If you do not speak English and need this form translated, please ask a staff member to arrange for language interpretation. It is free of charge.

ATENCIÓN: Si no habla inglés y necesita traducir este formulario, pídale a un miembro del personal que coordine la interpretación del idioma. Es gratis.

UWAGA: Jeśli nie mówisz po angielsku i potrzebujesz przetłumaczyć ten formularz, poproś członka personelu o zorganizowanie tłumaczenia ustnego. To jest bezpłatne.

注意：**如果您不会**说英语并需要翻译此表格，请让工作人员安排语言翻译。这个是免费的。

주의: 영어를 할 수 없고 이 양식을 번역해야 하는 경우 직원에게 언어 통역을 요청하십시오. 무료입니다.

Pansin: Kung hindi ka nagsasalita ng Ingles at kailangan ang form na ito na isinalin, mangyaring hilingin sa isang kawani na mag-ayos para sa interpretasyon ng wika. Ito ay walang bayad.

تنبيه: إذا كنت لا تتحدث الإنجليزية وتحتاج إلى ترجمة هذا النموذج ، فيرجى مطالبة أحد الموظفين بترتيب الترجمة الفورية للغة. إنه مجاني.

ВНИМАНИЕ: Если вы не говорите по-английски и вам нужен перевод этой формы, попросите сотрудника организовать языковой перевод. Это бесплатно.

ધ્યાન આપો: જો તમે અંગ્રેજી નથી બોલતા અને આ ફોર્મના અનુવાદની જરૂર હોય, તો કૃપા કરીને સ્ટાફ સભ્યને ભાષાના અર્થઘટનની વ્યવસ્થા કરવા માટે કહો. તે નિ:શુલ્ક છે.

توجہ: اگر آپ انگریزی نہیں بولتے اور اس فارم کا ترجمہ درکار ہے، تو براہ کرم عملے کے کسی رکن سے زبان کی تشریح کا بندوبست کرنے کو کہیں۔ یہ مفت ہے۔

LƯU Ý: Nếu bạn không nói được tiếng Anh và cần dịch mẫu đơn này, vui lòng yêu cầu nhân viên sắp xếp thông dịch ngôn ngữ. Nó là miễn phí.

ATTENZIONE: Se non parli inglese e hai bisogno di tradurre questo modulo, chiedi a un membro dello staff di organizzare l'interpretazione linguistica. È gratuito.

ध्यान दें: यदि आप अंग्रेजी नहीं बोलते हैं और इस फॉर्म का अनुवाद करना चाहते हैं, तो कृपया किसी स्टाफ सदस्य से भाषा की व्याख्या की व्यवस्था करने के लिए कहें। यह बिना मूल्य के है।

ATTENTION : Si vous ne parlez pas anglais et que vous avez besoin de traduire ce formulaire, veuillez demander à un membre du personnel d'organiser l'interprétation linguistique. C'est gratuit.

ΠΡΟΣΟΧΗ: Εάν δεν μιλάτε αγγλικά και χρειάζεστε μετάφραση αυτού του εντύπου, ζητήστε από ένα μέλος του προσωπικού να κανονίσει τη διερμηνεία γλώσσας. Είναι δωρεάν.

ACHTUNG: Wenn Sie kein Englisch sprechen und dieses Formular übersetzt werden müssen, bitten Sie einen Mitarbeiter, für eine Sprachübersetzung zu sorgen. Es ist kostenlos.