Promise Healthcare

GOOD FAITH ESTIMATE

Dental

819 Bloomington Rd. Champaign, Il 61820

Date of Good Faith Estimate: :_____

If scheduled, list the date(s) the Primary Service or Item will be provided:
What Provider is the Primary Service or Item scheduled with:
Provider NPI:
Check this box if this Service or Item is not yet scheduled. ☐

Patient Name: _____DOB: _____Med Rec #: _____
Address: _____City: _____State: _____Zip: _____

This information provided by Promise Healthcare (PHC) Good Faith Estimate (GFE) is an estimate of potential charges when a patient is seen at our clinic. All medical providers use a set of codes (CPT codes) established by the government to determine the complexity and value of an office visit or procedure. These codes may vary based on the type of visit occurring.

X	Service	Code	Full Fee	Discounted Fee
	PROPHYLAXIS - ADULT	D1110	$110.00	
	PROPHYLAXIS - CHILD	D1120	$88.00	
	Topical Fluoride Varnish	D1206	$46.00	
	SEALANT - PER TOOTH	D1351	$61.00	
	COMP ORAL EVALUATION - NEW EST PT	D0150	$109.00	
	Limit oral eval problem focused	D0140	$110.00	
	Periodic oral evaluation	D0120	$66.00	
	INTRAORAL PERIAPICAL FIRST FILM	D0220	$32.00	
	INTRAORAL-COMPLETE SERIES	D0210	$148.00	
	BITEWINGS - FOUR FILMS	D0274	$72.00	
	PANORAMIC FILM	D0330	$130.00	
	BITEWINGS - TWO FILMS	D0272	$50.00	
	EXTRACTION ERUPTED TOOTH EXPOSED ROOT	D7140	$200.00	
	SURGICAL REMOVAL ERUPTED TOOTH	D7210	$314.00	
	RESIN COMPOSITE - 1 SURFACE POSTERIOR	D2391	$200.00	
	RESIN COMPOSITE - 2 SURFACES POSTERIOR	D2392	$248.00	
	RESIN COMPOSITE - 3 SURFACES POSTERIOR	D2393	$310.00	
	RESIN COMPOSITE, >=4 SURFACES POSTERIOR	D2394	$363.00	

	RESIN COMPOSITE - 1 SURFACE ANTERIOR	D2330	$180.00	
	RESIN COMPOSITE - 2 SURFACES ANTERIOR	D2331	$220.00	
	RESIN COMPOSITE - 3 SURFACES ANTERIOR	D2332	$265.00	
	RESIN COMPOSITE - 4 SURFACES W INCISAL ANG	D2335	$329.00	
	PERIODONTAL SCALING & ROOT PLANING 1-3 TEETH	D4342	$197.00	
	PERIODONTAL SCALING &ROOT PLANING 4 TEETH-QUAD	D4341	$286.00	
	PERIODONTAL MAINTENANCE	D4910	$190.00	
	Interim Caries Arresting Medicament Application	D1354	$121.00	
	PREFABRICATED STAINLESS STEEL CROWN-PRIMARY TOOTH	D2930	$316.00	
	ANTERIOR ROOT CANAL	D3310	$1,024.00	
	MOLAR ROOT CANAL	D3330	$1,556.00	

Total Patient Estimated Amount: _____

All costs are due at the time of service. PHC does offer payment plans, as we want to ensure our patients receive the care they need with the ability to work with the Finance Department on payment structure.

Disclaimers:

PHC has tried to estimate the coding and the value attached based on the information provided at time of scheduling. PHC cannot always predict how each visit will be billed. So, by providing this estimate we disclose that we have tried our best to provide the patient with the total estimated cost of the appointment. *It will be the patient's responsibility to pay any additional cost above this estimate.*

Please be aware that the Good Faith Estimate provided to you includes the anticipated costs for the items and services listed. However, there may be additional items or services recommended by your convening provider or convening facility as part of your course of care. These additional items or services must be scheduled or requested separately and are not reflected in this estimate. For a comprehensive understanding of your potential costs, please discuss with your provider or facility.

The Good Faith Estimate provided to you is not a contract. It does not obligate you, as an uninsured (or self-pay) individual, to obtain the items or services from any of the providers or facilities listed in the estimate. You are free to seek care from any provider or facility of your choice.

If you have been billed more than $400 over the amount on this GFE, contact the Promise Billing department at 217-403-5403. 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 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 GFE. If the agency disagrees with you and agrees with the health care provider, you will have to pay the higher amount. To start the dispute process, go to www.cms.gov/nosurprises or call HHS at 312-353-5160.

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

Signed by Promise Healthcare Representative: _____

Signed Date: _____

GFE provided to patient via: Email ☐ US Mail ☐ Via Hand On ☐ _____ # of days before scheduled appt.

Copy sent to Medical Records Department: ☐