



Erie County Community Health Center  
 Provider NPI# 1700157492, 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	\$160			
Resin Two Surfaces Anterior	D2331	\$239			
Resin Three Surfaces Anterior	D2332	\$279			
Resin 4+ W/Incis Angel Anterior	D2335	\$319			
Resin Composite 1s; Posterior	D2391	\$160			
Resin Composite 2s; Posterior	D2392	\$319			
Resin Composite 3s; Posterior	D2393	\$431			
Resin Composite 4+s;Posterior	D2394	\$455			
Periodontal Maintenance	D4910	\$160			
scaling in the presence of gingivitis	D4346	\$718			

	Service	Code	Charge	% of Discount	Charge After Discount	Nominal fee
	Perio Scale & Root Plan 4+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 Impacted Tooth Partially Bony	D7230	\$479			
	Full Bony	D7240	\$575			
	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](http://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](http://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.



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	Service	Code	Charge	% of Discount	Charge after Discount	Nominal fee
	<b>Preventative</b>					
	New, Under the age of 1	99381	\$181			
	New, Ages 1-4	99382	\$189			
	New, Ages 5-11	99383	\$196			
	New, Ages 12-17	99384	\$220			
	New, Ages 18-39	99385	\$214			
	New, Ages 40-64	99386	\$247			
	New, 65 and older	99387	\$268			
	Est, Under the age of 1	99391	\$162			
	Est, Ages 1-4	99392	\$173			
	Est, Ages 5-11	99393	\$172			
	Est, Ages 12-17	99394	\$188			
	Est, Ages 18-39	99395	\$193			
	Est, Ages 40-64	99396	\$205			
	Est, 65 and older	99397	\$221			
	<b>Office Visits/Miscellaneous</b>					
	New	99202	\$120			
		99203	\$185			
		99204	\$277			
		99205	\$366			
	Est	99211	\$39			
		99212	\$94			
		99213	\$151			
		99214	\$213			
		99215	\$300			
	Drug Test	80305	\$15			
	Venipuncture	36415	\$4			
	Vivitrol Injection (Repository)	00011	\$20			

