Good Faith Estimate

Provider: Dahl-Chase Diagnostic Services/Dahl-Chase Pathology Associates, P.A.

Patient Name: _____

Procedure Scheduled: _____

Scheduled Date of Service: _____

Insurance: To be eligible for a Good Faith Estimate, patient must either have no insurance or be considered "Self Pay" (patient might have insurance, but prefer not to use it for this procedure)

Date of Service	Service Code	Description	Estimated amount to be billed
Total estimate of what you may owe:			

Name of Facility or Provider: _____

Provider Representative: _____
(Printed Name)

Provider Representative: _____
(Signature)

Contact Phone Number: _____ **Contact Fax Number:** _____

Date: _____

Fax completed form to: 207-947-4061

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