DESOTO MEMORIAL HOSPITAL

Estimate Request Form for Procedure, Treatment, or Test

Use this form to request a written estimate of the maximum amount that DMH charges to you and your insurance company. This may or may not be the final price that you pay for your care**. You may pay more or less for this procedure or service at another facility or in another health care setting.

If you are unable to pay amount estimated, we have financial assistance/charity care application available on our website (www.dmh.org) or by contacting a financial counselor at 863-494-8420.

How to use this form:
(1) Fill in Part 1.

(2) Return both pages of this form to the DMH, Attn. Patient Accounts-Estimates, P.O. Box 2177, Arcadia, FL 34265 or FAX to 863-491-4328.

(3) DMH will mail a written cost estimate to you within seven days of your request.

By signing this form, I understand:

This estimate is based on the insurance and clinical information available at the time of my request.

This estimate does not mean that my insurance company agrees to pay for my care at DMH.

This estimate may be based on the average payment received for the service bundle.

This estimate does not include the cost of: Physicians (Emergency Room, Attending Radiologists) or pathology services by SaraPath, or the price of medicine prescribed during your visit. Information regarding these providers may be found at www.dmh.org .

I may have to pay for other services resulting from my visit, but are not included in this estimate.

Because this form contains information protected by the Health Insurance Portability and Accountability Act (HIPAA), I will pick this form up in person or receive a written cost estimate through the mail.

_____ _____

Patient Name (First, Middle, Last) Patient/Guarantor Signature

_____

Date

**Contact your insurance company for a cost estimate that reflects your level of benefits, deductibles, and coinsurance.

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Part 1:	Patient Information (to be completed by patient or requestor)

This information in this section is required to submit a request.

Patient Information

Requestor Name: _____

Patient Name (if different than requestor): _____

Address: _____

_____

Telephone: _____

Date of Birth: _____

Procedure, Treatment or Test Description

Detailed description of procedure(s), treatment(s), or test(s) for which you are requesting an estimate. If you have the CPT ("Current Procedure Teminology") code related to the anticipated services, please include:

Part 2:	Coding and estimates (to be completed by DMH)

CPT Code	Procedure Description	Estimated Cost	Notes

DMH USE ONLY:

Prepared by: _____ Date Mailed: _____

Notes: _____