

# ESTIMATE OF WHAT YOU COULD PAY

PATIENT NAME: \_\_\_\_\_

OUT-OF-NETWORK PROVIDER(S) OR FACILITY NAME: Dr. Karol Gutowski / Dr. Andrea Martin

<b>Total cost estimate of what you may be asked to pay:</b>	
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- ▶ **Review your detailed estimate.** See Page 3 for a cost estimate for each item or service you may receive.
- ▶ **Call your health plan.** Your plan may have better information about how much you will be asked to pay. You also can ask about what’s covered under your plan and your provider options.
- ▶ **Questions about this notice and estimate?** Call 847-786-5200 (*aFresh Med Spa & Plastic Surgery*) to explain the documents and estimates to the individual, and answer any questions, as necessary.
- ▶ **Questions about your rights? Contact:**
  - The U.S. Centers for Medicare & Medicaid Services (CMS) at **1-800-MEDICARE** (1-800-633-4227) or visit <https://www.cms.gov/nosurprises> for more information about your rights under federal law.
  - The Illinois Department of Insurance, Office of Consumer Health Insurance at (877) 527-9431.

## PRIOR AUTHORIZATION OR OTHER CARE MANAGEMENT LIMITATIONS

Except in an emergency, your health plan may require prior authorization (or other limitations) for certain items and services. This means you may need your plan’s approval that it will cover an item or service before you receive the item(s) or service(s). If prior authorization is required, ask your health plan about what information is necessary to obtain coverage for the item(s) or service(s).

## UNDERSTANDING YOUR OPTIONS

You may also obtain the items or services described in this notice from providers who are in-network with your health plan. This differs with each health insurance plan. You should refer to your health plan for a specific list of providers who are in-network with your health plan.

## MORE INFORMATION ABOUT YOUR RIGHTS AND PROTECTIONS

Visit <https://www.cms.gov/nosurprises/consumers> for more information about your rights under federal law.



## More Details About Your Estimate

PATIENT NAME: \_\_\_\_\_

OUT-OF-NETWORK PROVIDER(S) OR FACILITY NAME: Dr. Karol Gutowski / Dr. Andrea Martin

The amount below is only an estimate; it isn't an offer or contract for services. This estimate shows the full estimated costs of the items or services listed. It doesn't include any information about what your health plan may cover. This means that **the final cost of services may be different than this estimate.**

**Contact your health plan to find out how much, if any, your plan will pay and how much you may have to pay.**

*Instructions for Provider:*

*Enter the good faith estimated cost for the items and services that would be furnished by the listed provider or facility plus the cost of any items or services reasonably expected to be provided in conjunction with such items or services. Assume no coverage would be provided for any of the items and services.*

*Populate the table below with each item and service, date of service, and estimated cost. Add additional rows if necessary. The total amount on page 2 must be equal to the sum total cost estimate included in the table.*

Date of Service	Service Code	Description	Estimate amount to be billed
<b>Total estimate of what you may owe:</b>			