dientes
COMMUNITY DENTAL

Good Faith Estimate / Estimación de Buena Fe

You have the right to receive a 'Good Faith Estimate' explaining how much your dental care will cost.

Tiene derecho a recibir un 'Estimado de Buena Fe' que explique cuánto costará su cuidado dental.

Under the law, healthcare providers need to give patients **who don't have insurance or who are not using insurance** an estimate of their bill for dental items and services.

Here's what you need to know:

- You have the right to receive a Good Faith Estimate of the expected cost of any non-emergency items or services.
- If you are eligible for a Good Faith Estimate, make sure your healthcare provider gives you one in writing at least 1 business day before you are to receive the medical service or item, unless your appointment is scheduled less than three days in advance. You can also ask your healthcare provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- Make sure to save a copy or picture of your Good Faith Estimate.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill through the U.S. Department of Health & Human Services.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises.

Según la ley, los proveedores de atención médica deben brindarles a los pacientes que no tienen seguro o que no usan un seguro una estimación de su factura por artículos y servicios dental.

Esto es lo que necesita saber:

- Tiene derecho a recibir una estimación de buena fe del costo esperado de cualquier artículo o servicio que no sea de emergencia.
- Si es elegible para un Estimado de buena fe, asegúrese de que su proveedor de atención médica le dé uno por escrito al menos 1 día hábil antes de que reciba el servicio o artículo médico, a menos que su cita esté programada con menos de tres días de anticipación. También puede pedirle a su proveedor de atención médica, y a cualquier otro proveedor que elija, un Estimado de buena fe antes de programar un artículo o servicio.
- Asegúrese de guardar una copia o una imagen de su estimación de buena fe.
- Si recibe una factura de al menos $400 más que su estimación de buena fe, puede disputar la factura a través del Departamento de Salud y Servicios Humanos de EE. UU.

Para preguntas o más información sobre su derecho a una estimación de buena fe, visite www.cms.gov/nosurprises.

PROVIDER DISPUTE RESOLUTION REQUEST

NOTE: SUBMISSION OF THIS FORM CONSTITUTES AGREEMENT NOT TO BILL THE PATIENT

INSTRUCTIONS

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Claims must have been paid or denied to be disputed. Provide additional information to support the description of the dispute. **Do not include a copy of the claim that was previously processed.**
- Multiple "LIKE" claims are for the same provider and dispute reason but different members and dates of service.
- Do not use this form for submitting a Corrected Claim.
- Mail the completed form to: **Dientes Community Dental Care, Attn: PDR**
  5300 Soquel Ave
  Suite 103
  Santa Cruz, CA 95062

***CLINIC NAME:**
***CLINIC ADDRESS:**

***PROVIDER TYPE** ☐Dental ☐ Hygiene ☐ Specialty Care ☐ Other

(please specify type of "other")

***CLAIM INFORMATION** ☐ Single ☐ Multiple "**LIKE"** Claims (complete attached sheet) *Number of claims*:_____

***Patient Name:**	***Date of Birth:**
***Dientes Patient ID Number:**	***Original Claim ID Number:** (If multiple LIKE claims, use attached sheet)

Service "From/To" Date: (*Required for Claim, Billing, and Reimbursement Of Overpayment Disputes)	***Original Claim Amount Billed:**	***Original Claim Amount Paid:**

***DISPUTE TYPE**

☐ Claim
☐ Appeal of Necessity / Utilization Management Decision
☐ Disputing Request For Reimbursement Of Overpayment
☐ Seeking Resolution Of A Billing Determination
☐ Contract Dispute
☐ Other:

***DESCRIPTION OF DISPUTE:**

EXPECTED OUTCOME:

Contact Name (please print)	**Title**	**( ) Phone Number**
Signature	**Date**	**( ) Fax Number**