Good Faith Estimate Request Form for Self-Pay Patients

Date of Request: _____

Attention: Pathology Services Laboratory-GFE Request

Fax Request to : 479-968-3074

Name of Convening Provider/Facility:	
Name of Contact at Provider's Office/Facility:	Phone:
Street Address:	Fax:
City, State, Zip:	Email:
Please indicate the method by which you prefer to receive the good faith estimate.	Contact Preference: [ ] Fax [ ] Email

Patient's Full Name:	Birthdate:	Gender:
Mailing Address:	SSN:	[ ] Male
City, State, Zip:	Phone:	[ ] Female
Email:	Contact Preference: [ ] Phone [ ] Email [ ] Mail	

If scheduled, list the date(s) of service:	[ ] Check here if not yet scheduled.
Procedure to be performed:	Patient's Primary Diagnosis:
List any expected/anticipated pathology orders:	Any Additional Related Diagnoses:

Please include or attach all information or documents necessary for Pathology Services Lab to determine what related items or services to expect.