2025 Good Faith Estimate for Health Care Items and Services

Patient Demographics	
Last Name, First Name, Middle Initial:	
Date of Birth:	
Patient Identification Number:	
Patient Mailing Address:	
Phone Number:	
Email Address:	
Patient's Contact Preference (check box): Mail ☐ Email ☐	

Patient Diagnosis (self-reported)	
Primary Service or Item Requested/Scheduled:	
Primary Diagnosis:	
Primary Diagnosis Code:	
Secondary Diagnosis:	
Secondary Diagnosis Code:	

Scheduling	
Date(s) the Primary Service will be provided:	
Check box if this Service is not yet scheduled:	

Date of Good Faith Estimate:		
Good faith estimate will be updated if changes in patient care plan significantly alters estimated cost. The estimates provided below are per day based on type of service being provided. The estimated costs are valid for 12 months from the date of the Good Faith Estimate.		
Service Type	**Billing Code**	**Estimated Amount**
Routine Home Care	Q5001	$285/Day

Hospice Daily Rate is charged on a continuous daily basis from start of care to discharge date, regardless of if the patient is seen daily. Hospice daily rate covers supplies and equipment that may be necessary for pain relief and symptom management.

Disclaimer

The information provided in this good faith estimate is only an estimate regarding items or services reasonably expected to be furnished at the time this good faith estimate is issued to you and actual items, services, or charges may differ from this good faith estimate. There may be additional items or services that your provider recommends as part of your course of care that must be scheduled or requested separately and are not

reflected in this good faith estimate.

If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill. You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available. You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill. There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount. To learn more and get a form to start the process, go to www.cms.gov/nosurprises or call 1-800-985-3059.

This good faith estimate is not a contract and does not require you to obtain the items or services from any of the providers or facilities identified in this good faith estimate.

Entities covered under this GFE that may be providing this service.

State	Legal Name	DBA	Address	TIN	NPI
OH	ComfortBrook Hospice, LLC	Grace Hospice	4435 Aicholtz Rd, Ste 400, Cincinnati, OH 45245-1691	20-1530070	1205352051
OH	ComfortBrook Hospice, LLC	Grace Hospice	7206 Market St., Ste C, Youngstown, OH 44512-4562	20-1530070	1871019463