Greenbelt Anesthesia Associates

9821 Greenbelt Road Suite 104, Lanham MD 20706
Telephone No.: 301-552-1801

INFORMATION NOTICE REGARDING YOUR HEALTH INSURANCE/ASSIGNMENT OF BENEFITS/GOOD FAITH ESTIMATE

Patient name: ______________________________ DOB: ____________________

This notice is to inform you that Greenbelt Anesthesia Associates is Out-of-network with your current health insurance plan. However, since your provider and Greenbelt Endoscopy Center are in-network with your insurance plan, your health plan may consider to reimburse your anesthesia as an in-network service.

The amount below is only an estimate based on duration of your procedure; 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.

Date of Service	Service Code	Description	Estimated Amount to be billed
	EGD 00731	Upper Endoscopy	$900
	Colon 00811/00812	Colonoscopy	$1,350
	Double 00813	Upper Endoscopy & Colonoscopy	$2,025

- **Review your detailed estimate**.
- **Call you health plan** -Your health plan may have better information about how much if any, your plan will pay and 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** – Our billing department will contact you at least 2-3 days prior to your procedure. You may also contact one of our Representatives at 301-823-8070 or 301-345-7413 to explain this document, estimate and answer any questions.
- **Deductibles/Copay/Co-Insurance** – Any copays/deductible/co-insurance will be collected on the date of the procedure.
- **Timeframe required to sign this form** – Please sign this form at least 72 hours prior to your scheduled procedure. You may email this form back to Greenbelt Anesthesia Associates at **Insurance@greenbeltendoscopy.com**. If this form is not signed/received at least 72 hours prior to your procedure, your procedure will be cancelled.
- **Questions about your rights** – Contact 1-800-985-3059 for more information. TTY users can call 1-800-985-3059 or visit CMS.gov/nosurprises.

IMPORTANT: I was given a written notice (Paper and/or electronically) on____________________ explaining that my anesthesia provider isn't in my plans network. It also included a good faith estimate of the anesthesia services. I understand that I don't have to sign this form, however, if I refuse to sign it, this facility can refuse to treat me. I also understand that I can choose to get care from a provider in my health plan's network.

Patient's Signature: ____________________ Print name of patient: ____________________

Date: ____________________ Time: ____________________