Sample Estimate

Estimate: An approximate calculation of the amount you will be responsible for paying after insurance.

Your unique insurance information

Deductible, Out of Pocket, Co-Pay and Co-insurance information applied at the time of estimate

Estimated amount due after Deductible, Co-Pay and Co-insurance have been applied.

Common billing definitions to help you understand your estimate, statement, bill, etc.

CPT (test codes) and ICD-10 (diagnosis codes) taken from your physician's order to run the esti-

Disclaimer: Estimates may change due to various reasons. Read carefully to understand how the esti-

WESTERN RESERVE HOSPITAL
Proudly Physician Owned

Western Reserve Hospital
1900 23rd Street
Cuyahoga Falls, OH 44223-1404
Phone: 330-971-7597

ESTIMATE WORKSHEET

Patient Name:	Deanna Test Phone:(330) 999-9999
Service Date:	5/18/2017
Account #:	000000000
Policy Number:	
Group Number:	
Insurance Company:	Medical Mutual of Ohio (MMO) - Traditional

This estimate is based on the following codes:

Facility Codes (CPT®):
70553 TC : MRI BRAIN STEM W/O & W/DYE

ICD-10's:
R51 (Diag) : HEADACHE

Deductible:	$100.00
Deductible Met:	$100.00
Out of Pocket Max:	$650.00
Out of Pocket Met:	$225.00
Co-Pay:	$0.00
Co-Insurance:	20%

Co-Pay:	$0.00
Deductible:	$0.00
Co-Insurance:	$425.00
Total:	**$425.00**

Total Estimated Charges
$9,814.00

Total Estimated Patient Amount
$425.00

Ins Rep: Test - (000) 000-0000 - 05/18/2017

Est ID: 5237

THIS IS AN ESTIMATE ONLY

We are very pleased that you have chosen Western Reserve Hospital for your healthcare services. Please be aware that this estimate may change due to changes in pricing or any change in your insurance coverage. Please contact us to allow us to update this estimate as needed. The above costs associated with your visit are an ESTIMATE of your portion of the balance, based on your insurance benefits. Please remember that the contract with your insurance company is ultimately your responsibility. We recommend that you contact your insurance company to inform them of your visit and verify that they have all of the information they will need to process and approve claims. We will honor any contracts we may have with them; however, you are responsible for your deductible, co-payment, and/or co-insurance. These benefits are only an estimate of coverage and not a guarantee of payment. For questions please call (330) 971-7597.

Definitions

Deductible: The amount you have to pay each year before your plan starts paying benefits

Out of Pocket: The amount your insurance company requires you to pay before you are no longer subject to co-insurance

Co-Pay: The amount that your insurance company expects you to pay upon each visit/service

Co-Insurance: The percentage of the amount covered that your insurance requires you to pay

Total Estimated Charges: The estimated charge(s) for the service provided

Total Estimated Patient Amount: The estimated amount you will be responsible for paying

Date:

OFFICE USE ONLY

Notes:

Prepared By: 88617