

## **Medical Services Cost Estimate Instructions:**

To request information regarding the cost for proposed medical services, complete the Medical Services Cost Estimate Request form below.

The accuracy of the estimate that we provide to you will depend largely on the specificity and accuracy of the information you provide to us regarding your proposed medical service. Additionally, the longer you wait to undergo the proposed medical treatment after you receive our estimate, the more likely actual results will vary from the estimate.

Please be prepared to provide us with the following information in order to process your estimate request:

- Name and Demographics of Patient
- Insurance Policy Number
- Name of Primary Insured
- Type of Procedure or Service  
(if you will be receiving more than one service or procedure, please fill out a separate form for each)
- Date the Procedure or Service is expected to be rendered
- Name of Medical Provider performing the Procedure or Service

Obtain this information from your Medical Provider; it will enable us to provide you with a more accurate estimate

- Diagnosis (the actual diagnosis for the care to be rendered)
- CPT codes

If you have questions, please call Elaine Rice at (406) 271-3211 ext 236.



# Pondera Medical Center

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406.271.3211 • www.ponderamedical.com

## Request for Medical Services Cost Estimate

Patient Name: \_\_\_\_\_ Patient Birth Date: \_\_\_\_\_

Street Address: \_\_\_\_\_ Social Security No: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Have you been a patient at Pondera Medical Center in the past?  Yes  No

Anticipated Procedure/Service: \_\_\_\_\_

Anticipated Date of Procedure/Service: \_\_\_\_\_

Physician Performing Procedure/Services: \_\_\_\_\_

Procedure/Service CPT: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Do you have insurance that may pay for some of the costs associated with the anticipated procedure/service?

Yes  No If yes, please complete the information below and provide a copy of your insurance card.

Insurance Co Name: \_\_\_\_\_ Contract #: \_\_\_\_\_

Street Address: \_\_\_\_\_ Group Name: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Subscriber Birth Date: \_\_\_\_\_

Have the anticipated services been pre-certified by your insurance company?  Yes  No

### Only an Estimate

Please be aware the cost information you will receive is a good faith estimate only. While we make every effort to ensure the accuracy of our cost estimates, medical care and diagnostic testing can take different turns. Therefore, you will receive an estimate and not a guarantee of the cost of this service. Your physician may choose to do a different test or order additional tests to provide you the best care which will not be included in the cost estimate and may result in additional charges. The cost of supplies or other materials that may be needed to perform the additional test/procedure will also not be included in the cost estimate.

### Disclosures

Each person's health needs vary, the price given is only an estimate and will depend on the individuals' specific situation; as a result you may have additional financial responsibility.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Mail Form to:  
Pondera Medical Center  
Attn Cost Estimate  
PO Box 668  
Conrad MT 59425

Please allow 10 business days to process your estimate. You will receive a letter once an estimate has been completed.