Estimated Cost for Out-of-Network Services

Patient Name: _____

Account Number: _____

Primary Insurance Plan: _____

Date Estimated Costs Issued to Patient: _____

Estimated service codes and fees for appointment dated _____ for which the Advocare Provider is out-of-network with your current Health Plan are listed below.

The services and fees listed below are an estimate and are determined barring any unforeseen medical issues that may arise during your scheduled appointment. If you choose to proceed with the scheduled appointment, please be aware that you may have financial responsibility that will exceed your copayment, deductible and coinsurance. Should you have further questions regarding the potential costs associated with your visit, please contact your health insurance plan for further guidance.

Service or Procedure Name:_____ CPT:_____ Estimated Fee ($):_____

Service or Procedure Name:_____ CPT:_____ Estimated Fee ($):_____

Service or Procedure Name:_____ CPT:_____ Estimated Fee ($):_____

Service or Procedure Name:_____ CPT:_____ Estimated Fee ($):_____

ESTIMATED TOTAL ($):_____