Lawrence General Hospital

So good. So caring. So close.

REQUEST A WRITTEN COST ESTIMATE

Thank you for considering Lawrence General Hospital for your upcoming procedure**. If you are currently covered under a health insurance plan, please contact your insurance provider to obtain a Cost Estimate.** If you are not currently covered by a health insurance plan, you may contact Patient Financial Services at 978-683-4000, x 3367. Please leave a message and Patient Financial Services will contact you with the options available to you.

Use this form, if you are an uninsured patient and would like to get an estimate of your financial responsibility for an upcoming service or procedure. Fill out the form completely by following the instructions and by obtaining the required information from your provider.

Important information about this estimate: Estimates are based on the information provided to Lawrence General Hospital and medical information available at the time the estimate is requested. The cost estimates only reflect those services listed on the form. Please check with your Provider that you have been given the information for all anticipated services. If this information should change, the actual amount you will be responsible for may vary. Note that for many types of services, there are typically separate charges from multiple providers such as anesthesiologists, radiologists, pathology, tests or screenings. If you have questions or need help, please call the **Cost Estimator Hotline** at **978-683-4000 ext. 3367** or email us at costestimator@lawrencegeneral.org

How to submit the form to us: Please fill out **Section 1** (Patient Information) completely. Have your **Provider** complete the Procedure information in **Section 2.**

DO NOT EMAIL COMPLETED FORM

Mail the completed form to: Lawrence General Hospital
Attn: Cost Estimator-Patient Financial Services
1 General Street
Lawrence, MA 01842

Or

Fax your form to: 978-946-8039

DO NOT EMAIL COMPLETED FORM

Request a Written Cost Estimate for Services

SECTION 1: PATIENT INFORMATION (Please fill out completely)		
NOTE:	**IF YOU ARE COVERED BY INSURANCE- DO NOT COMPLETE THIS FORM. PLEASE CONTACT YOUR INSURANCE CARRIER FOR A COST ESTIMATE**	
PREFERRED LANGUAGE	☐ **ENGLISH** ☐ **SPANISH**	
NAME:		
PHONE NUMBER:	**(___) _____ - _____** ☐ **CHECK BOX IF OK TO LEAVE A MESSAGE**	
STREET:		
CITY:		
STATE:		**ZIP CODE:**

*Check a box below to let us know how you would like the cost estimate sent to you. It can be emailed-**will be encrypted**- sent through regular mail or faxed. E-mail/fax will be delivered within 2 business days. Mail will be sent out in 2 business days to your address that you have provided above. Should we have a question, we will call you at your phone number that you have provided above.*

☐ **POSTAL MAIL TO ADDRESS LISTED ABOVE**

☐ **EMAIL ADDRESS (will be encrypted): _____@ _____**

☐ **FAX NUMBER: (_____) _____- _____**

SECTION 2: PROCEDURE INFORMATION (Detail Procedure & Diagnosis as well as description will help facilitate our completion of this Estimate. Your physician will provide you with this information.)

PLEASE HAVE YOUR PROVIDER FILL OUT THE SECTION BELOW:

SERVICES PROVIDED AT: LAWRENCE GENERAL HOSPITAL	**LGH NPI # 1750381281**
PROCEDURE CODES	**DIAGNOSIS CODES**

Procedure Code/CPT Code (Current Procedural Terminology), which identifies treatment being performed, or HCPCs Code (Health Care Procedural Coding System), which identifies outpatient **services being performed. Diagnosis Codes (one per procedure if available) ICD-10 Code (International Classification of Diseases, Volume 10), which identifies diagnosis.**