

KIRBY MEDICAL GROUP
Good Faith Estimate for Health Care Items and Services

Patient

First Name

Middle Name

Last Name

Patient Date of Birth:

Account #:

Patient Mailing Address, Phone Number, and Email Address

Street or PO Box

Apartment

City

State

Zip Code

Phone

Email Address

Patient's Contact Preference: By mail By email

Date of Scheduled Service:

Check if not yet scheduled:

Kirby Medical Center Estimate

Provider/Facility Name

Kirby Medical Group

Provider/Facility Type

Clinic

Street Address

1000 Medical Center Drive

City

Monticello

State

IL

Zip Code

61856-2116

Contact Person

Phone

217-762-1540

Email

insurancestaff@kirbyhealth.org

National Provider Identifier

1558527259

Taxpayer Identification Number

370661215



Primary service or item requested/scheduled:

Primary and secondary diagnoses codes:

Total Expected Charges:

Date of Good Faith Estimate:

The following is a detailed list of expected charges for , scheduled for . The estimated costs are valid for 12 months from the date of the Good Faith Estimate.

DISCLAIMER:

If you have not applied for financial assistance and wish to do so, please contact our Financial Services Department at 217-762-1540 to apply. The Financial Assistance application can also be found at <https://www.kirbyhealth.org/documents/KIRBY-FINANCIAL-ASSISTANCE-APPLICATION.pdf>.

The following page(s) is a detailed list of expected charges for the primary service(s) and date(s) listed above.

For recurring services, the estimated costs are valid for 6 months from the date of the Good Faith Estimate.

Kirby Medical Center and our Rural Health Clinics update their charges typically every July 1st. As such, if you have services that will span before and after July 1st, please contact the Kirby Medical Center's Financial Services Department at 217-762-1540 to obtain an updated estimate of your out-of-pocket costs.

