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 Cerro Gordo Rural Health Clinic		**Provider/Facility Type** Clinic
Street Address 407 S Jackson St, Ste A, PO Box 230		
City Cerro Gordo	**State** IL	**Zip Code** 61818-4356
Contact Person	**Phone** 217-762-1540	**Email** insurancestaff@kirbyhealth.org
National Provider Identifier 1508219288	**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 any services that will span before and after July 1st, please contact the Kirby Medical Center's Financial Services Department at 217-762-1540 to obtian an updated estimate of your out-of-pocket costs.