The HARRIS CENTER for Mental Health and IDD

Transforming Lives

GOOD FAITH ESTIMATE FOR HEALTH CARE ITEMS AND SERVICES

Based on the information available at the time of this estimate, the services below may be on the Recovery Plan completed by you and your care coordinator. The amount and duration of services you will receive is based on what you agreed to on your Recovery Plan and as determined by your Needs Assessment. There may be additional items or services the Harris Center recommends as part of your treatment that must be scheduled or requested separately and are not reflected in this good faith estimate. A separate good faith estimate will be provided at the time any additional services are requested or scheduled. Please note the amounts indicated below reflect services at a full fee rate. Your financial responsibility is determined by your financial assessment which includes a review of your Monthly Ability to Pay and any available insurance coverage.

CPT/HCPS Codes	Procedure Code Definition	Procedure Modifier	Unit Charge (UCR)
36415	CHG COLLECTION VENOUS BLOOD, VENIPUNCTURE		10.80
90791	PR PSYCHIATRIC DIAGNOSTIC EVALUATION		250.00
90792	PR PSYCHIATRIC DIAGNOSTIC EVAL W/MEDICAL SERVICES		300.00
90832	PR PSYCHOTHERAPY PATIENT &/ FAMILY 30 MINUTES		130.00
90834	PR PSYCHOTHERAPY PATIENT &/ FAMILY 45 MINUTES		165.00
90837	PR PSYCHOTHERAPY PATIENT &/ FAMILY 60 MINUTES		250.00
90846	PR FAMILY PSYCHOTHERAPY, NO PT		175.00
90847	PR FAMILY PSYCHOTHERAPY W PHYS		175.00
90853	PR GROUP PSYCHOTHERAPY		53.00
93000	PR ELECTROCARDIOGRAM, COMPLETE		32.00
93005	12 LEAD EKG		21.00
96101	PR PSYCHOLOGIC TESTING BY PSYCH/PHYS		94.00
96372	PR INJECTION,THERAP/PROPH/DIAGNOST, IM OR SUBCUT		34.00
99202	PR OFFICE OUTPATIENT NEW 20 MINUTES		193.00
99203	PR OFFICE OUTPATIENT NEW 30 MINUTES		250.00
99204	PR OFFICE OUTPATIENT NEW 45 MINUTES		320.00
99205	PR OFFICE OUTPATIENT NEW 60 MINUTES		450.00
99211	PR OFFICE OUTPATIENT VISIT 5 MINUTES		61.00
99212	PR OFFICE OUTPATIENT VISIT 10 MINUTES		100.00
99213	PR OFFICE OUTPATIENT VISIT 15 MINUTES		122.00
99214	PR OFFICE OUTPATIENT VISIT 25 MINUTES		185.00
99215	PR OFFICE OUTPATIENT VISIT 40 MINUTES		375.00
99382	PREVENTIVE VISIT, NEW, AGE 1-4		145.00
99383	PREVENTIVE VISIT, NEW, AGE 5-11		144.00
99384	PREVENTIVE VISIT, NEW,12-17		157.00
99385	PR PREVENTIVE VISIT, NEW,18-39		157.00
99386	PREVENTIVE VISIT, NEW,40-64		147.00
99387	PREVENTIVE VISIT, NEW,65 & OVER		161.00
99392	PREVENTIVE VISIT, EST, AGE 1-4		124.00
99393	PREVENTIVE VISIT, EST, AGE 5-11		133.00
99394	PREVENTIVE VISIT, EST,12-17		145.00
99395	PR PREVENTIVE VISIT, EST,18-39		145.00
99396	PREVENTIVE VISIT, EST,40-64		120.00

99397	PREVENTIVE VISIT, EST,65 & OVER		134.00
99441	PR PHYS/QHP TELEPHONE EVALUATION 5-10 MIN		100.00
99442	PR PHYS/QHP TELEPHONE EVALUATION 11-20 MIN		122.00
99443	PR PHYS/QHP TELEPHONE EVALUATION 21-30 MIN		185.00
G0402	PR INITIAL PREVENTATIVE EXAM		272.00
G0438	PR PPPS, INITIAL VISIT		258.00
G0439	PR PPPS, SUBSEQ VISIT		202.00
H0034	PR MED TRNG & SUPPORT PER 15MIN		20.00
H0034	PR MED TRNG & SUPPORT PER 15MIN	HQ	4.00
H2011	PR CRISIS INTERVEN SVC, 15 MIN		54.00
H2014	PR SKILLS TRAIN AND DEV, 15 MIN		37.00
H2014	PR SKILLS TRAIN AND DEV, 15 MIN	HQ	8.00
H2017	PR PSYSOC REHAB SVC, PER 15 MIN		39.00
H2017	PR PSYSOC REHAB SVC, PER 15 MIN	HQ	7.00
H2019	PR THER BEHAV SVC, PER 15 MIN		20.00
H2023	PR SUPPORTED EMPLOY, PER 15 MIN		37.00
H2025	PR SUPPORT MAINTAIN EMPLOYMENT, 15 MIN		37.00
J0400	PR INJECTION, ARIPIPRAZOLE, IM, 0.25 MG		21.00
J0515	PR INJ BENZTROPINE MESYLATE		53.00
J1200	PR DIPHENHYDRAMINE HCL INJECTIO		2.00
J1630	PR HALOPERIDOL INJECTION		8.00
J1631	PR HALOPERIDOL DECANOATE INJ		41.00
J2060	PR LORAZEPAM INJECTION		11.00
J2426	PR PALIPERIDONE PALMITATE INJ		12.00
J2550	PR PROMETHAZINE HCL INJECTION		4.00
J2680	PR FLUPHENAZINE DECANOATE 25 MG		24.00
J2794	PR INJ RISPERDAL CONSTA, 0.5 MG		11.00
J3230	PR CHLORPROMAZINE HCL INJECTION		34.00
J3486	PR ZIPRASIDONE MESYLATE		46.00
Q3014	PR TELEHEALTH FACILITY FEE		29.00
T2011	PR PASRR LEVEL II		50.92
HC96130	PR PSYCHOLOGICAL TESTING EVAL SVC PROFESSIONAL		195.00
HC96131	PR PSYCHOLOGICAL TESTING EVAL SVC PROF ADDTL 60		145.00
HC96136	PR TEST ADMIN AND SCORING PROFESSIONAL		73.00
HC96137	PR TEST ADMIN AND SCORING PROF ADDTL 30		65.00
HCH0038	PR PEER SUPPORT - AFFILIATE		18.00
HCH0038	PR PEER SUPPORT - AFFILIATE	HQ	3.00
HC90792.2	PR URGENT DIAGNOSIS ASSESSMENT - AFFILIATE		1,100.00
HC90792.3	PR EMERGENT DIAGNOSTIC ASSESSMENT - AFFILIATE		1,600.00
HC90792.4	PR ORDERING 24HR. OBSERVATION - AFFILIATE		1,800.00
HCT1017.1	PR MENTAL HEALTH ADULT ROUTINE CASE MANAGEMENT - AFFILIATE		29.00
HCT1017.2	PR IDD TYPE B CASE MANAGEMENT - AFFILIATE		35.00
HCT1017.3	PR MENTAL HEALTH CHILD ROUTINE CASE MANAGEMENT - AFFILIATE		35.00
HCT1017.4	PR ECI CASE MANAGEMENT - AFFILIATE		38.00
HCT1017.5	PR MENTAL HEALTH INTENSIVE CASE MANAGEMENT - AFFILIATE		46.00
HCT1017.6	PR IDD TYPE A CASE MANAGEMENT - AFFILIATE		107.00
T2020	PR DAY HABIL WAIVER PER DIEM		100.00
HC3456	PR RESPITE (ROUTINE) - AFFILIATE		14.00
H2015	PR COMP COMM SUPP SVC, 15 MIN		7.00

Disclaimer

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.

If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill.

You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill.

There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

To learn more and get a form to start the process, go to www.cms.gov/nosurprises/consumers or call 1-800-985-3059.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises/consumers or call 1-800-985-3059.

Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.

This Good Faith Estimate is not a contract and does not require you to obtain the services from The Harris Center.

Client Signature: _____ **Date:** _____

Staff Name: _____ **Date:** _____