



HEALTH & WORK

Self-Pay Follow-Up Care Estimate and Bill Dispute Workbook

For scheduled uninsured or self-pay follow-up care, preserve a good-faith estimate, compare it with the bill and prepare an eligible patient-provider dispute packet.

WHAT THIS WORKBOOK HELPS YOU DO

01

Complete your estimate request
and scope

02

Complete your provider-level bill
comparison

03

Complete your eligibility and
deadline verification

For people handling accident-related paperwork and preparing clear, evidence-backed questions.

Use it on screen or on paper. Save a personal copy before entering information. Blank response areas are fillable; printed copies work just as well. Keep completed copies private.

Scope. Educational organization tools, not legal, medical, tax or financial advice. No claim result, coverage decision or payment is promised. Verify policy language, current local rules and all deadlines with the appropriate professional or official source.



START HERE

Start with a clear working file

Work on one claim, account or issue at a time. Keep originals unchanged and label working copies with a short evidence ID. Complete the guidance in order, then use the worksheets to turn questions into an organized next step.

A practical order

- 01 Read the four guidance pages before filling the worksheets. Mark facts you can support and questions that still need an answer.

GUIDANCE / PAGES 03-06

- 02 Use the fictional examples to check your method. Their facts and dollar amounts do not describe your claim or predict an outcome.

EXAMPLES / PAGE 07

- 03 Complete the four working sheets, then use the readiness check and next-step page. Duplicate a worksheet when you need another record.

WORKSHEETS / PAGES 08-11

Protect your information

Store completed copies somewhere private. Use a claim or account suffix when a full identifier is unnecessary. Share only relevant copies through a verified recipient and appropriate channel. A saved PDF can contain personal information even when it is not open on screen.

Before a deadline. Do not wait to finish this workbook when a notice, release, court paper or policy deadline needs attention. Verify the actual requirement and seek qualified help promptly.



GUIDANCE 1

01

Screen for the correct self-pay situation

Start by recording whether you did not have insurance or chose not to use it for the scheduled service, and what you told the provider before care. The federal good-faith-estimate process discussed here is not a substitute for emergency treatment or an insured claim appeal. Do not delay urgent care to obtain paperwork. A patient may be eligible for one billing protection but not another, so retain the coverage and scheduling facts rather than assuming every unexpectedly high medical bill qualifies for this dispute route.

Request a written estimate for defined services

Identify the provider, location, anticipated service and planned dates. Ask for a written good-faith estimate using the provider's current process, and keep the request and response. Clarify which providers or facilities are included and whether you need separate estimates. A telephone price quote and a compliant estimate may not be equivalent. Record uncertainty about additional services or separate billers before the appointment. This worksheet helps you ask administrative questions; it does not recommend treatment or guarantee that the anticipated services will be the only care needed.

RELATED WORKING SHEETS

- Estimate request and scope
- Eligibility and deadline verification

Sources for this page: [1], [2], [3]. See the linked source guide.



GUIDANCE 2

02

Preserve versions and scope changes

Save each estimate exactly as received, with its issue date and the date you received it. If the service changes or the provider issues a new estimate, keep both versions and note what changed. Preserve messages about additional services, scheduling or provider changes. Do not rewrite an estimate after the fact to match your memory. When there are several providers, keep separate folders or rows so their estimated totals and later bills are not combined into an artificial dispute threshold.

Match the bill to the estimate

Compare the provider or facility, service description, dates and amounts. Mark services that do not obviously match and ask for an explanation. Keep the initial bill and later revisions because the initial bill's date or receipt can be important to the process. A simple difference is only a screening calculation, not a decision about the final payment. Record the provider-level total used and identify any uncertainty about included services before proceeding to the eligibility checklist.

Compare one provider's estimate and bill; keep scope changes and unmatched services visible.



Sources for this page: [1], [2], [3]. See the linked source guide.



GUIDANCE 3

03

Check current dispute eligibility and timing

Centers for Medicare & Medicaid Services (CMS) currently describes eligibility conditions that include uninsured or self-pay status, prior communication to the provider, a qualifying good-faith estimate, a bill from one provider or facility at least \$400 above its estimate and a 120-calendar-day filing window tied to the initial bill. Read the current CMS instructions because additional conditions matter, including estimate and scheduling details. Record the exact official wording and the relevant dates. If timing or eligibility is uncertain, seek CMS guidance promptly rather than assuming a workbook calculation preserves the opportunity.

Ask for clarification without losing time

You may first ask the provider to explain the difference and whether it will correct or adjust the bill. Use the estimate and bill side by side and identify the disputed services. Record any offer in writing and review its terms before agreeing. An informal conversation should not be assumed to extend the federal dispute window. Keep the filing-date field visible while clarification is pending. Do not accept an unsupported statement that a revised invoice restarts every deadline; verify that question with the official process.

RELATED WORKING SHEETS

- Provider-level bill comparison
- Eligibility and deadline verification

Sources for this page: [1], [2], [3]. See the linked source guide.



GUIDANCE 4

Assemble the official submission packet

04

Use the current CMS application or approved route rather than treating this workbook as the filing itself. Prepare the estimate, initial bill, later relevant correspondence and concise explanation of the difference. Check current administrative fees and submission requirements on the official page immediately before filing. Label attachments so the reviewer can identify which provider and estimate each document concerns. The independent reviewer determines the appropriate payment under the process. The workbook does not promise that the bill will be reduced to the estimate or eliminated.

Verify the result and account update

Keep the eligibility response, dispute reference and final decision together. Read any required next steps, payment instructions or deadlines in the actual decision. Compare the provider's resulting statement with the outcome and raise mismatches through the stated route. If you do not qualify for the federal process, record the reason and ask about another official assistance option. Close the file only when the outcome and account status are clear. A completed worksheet, a submitted request and an accepted dispute are three different milestones.

RELATED WORKING SHEETS

- Provider-level bill comparison
- Eligibility and deadline verification

Sources for this page: [1], [2], [3]. See the linked source guide.



FICTIONAL EXAMPLES

Work through the examples

These invented cases demonstrate the method. They are not case results, estimates of what you will receive or statements of universal rights.

01 Fictional: provider-level threshold

Provider A estimated \$700 and billed \$1,150, a \$450 difference. Provider B estimated \$300 and billed \$550, a \$250 difference. Provider A meets the amount component of the federal screen; Provider B does not on these figures. The workbook then checks the other eligibility conditions instead of treating the threshold alone as approval.

02 Fictional: do not pool small overages

Two separate providers each bill \$250 above their own estimate. Adding them to \$500 does not establish a \$400 excess for either provider. Keep them separate and ask CMS about the appropriate route if other facts matter.



WORKSHEET 1

01

Estimate request and scope

Save actual written estimates; distinguish them from informal quotes.

Provider/facility

Coverage/self-pay status

Provider notified date

Scheduled service/date

Request date

Estimate received date

Estimated services

Separate billers

Version/date

Unresolved scope

[Related guidance: Screen for the correct self-pay situation](#)



WORKSHEET 2

02

Provider-level bill comparison

Compare one provider or facility at a time; do not pool unrelated bills.

Provider

Estimate version

Estimated total

Initial bill issue/receipt dates

Billed total

Difference

Matched services

Unmatched items

Supporting pages

Related guidance: [Check current dispute eligibility and timing](#)



WORKSHEET 3

03

Eligibility and deadline verification

Every uncertain criterion remains a question, not an assumed yes.

CMS page checked/date

Coverage criterion

Estimate criterion

Service date criterion

Amount criterion

Initial bill dates

Official window wording

Verified due date/source

Uncertainty/help request

Related guidance: [Check current dispute eligibility and timing](#)



WORKSHEET 4

04

Submission and result audit

Informal negotiation does not replace checking the official filing window.

Provider contact attempt

Written offer/terms

Official submission date/proof

Current fee verified

Case reference

Documents sent

Eligibility response

Decision

Account adjustment

Remaining deadline

[Related guidance: Assemble the official submission packet](#)



READINESS REVIEW

Check the file before using it

REVIEW EACH ITEM BEFORE MOVING ON

- ☐ Each working figure or statement is linked to an identifiable document.
- ☐ Missing information is marked as unverified rather than estimated as fact.
- ☐ The exact question and the person or organization able to answer it are identified.
- ☐ The current document version and any conflicting version are preserved.
- ☐ Independent deadlines and the source of each deadline have been checked.
- ☐ The final written response has been compared with the original question.

What still needs attention

Open fact or decision, who can resolve it, and the source needed

Completion standard. The working file is complete when the important facts are supported, the next action is assigned and any unresolved issues remain clearly visible. A completed checklist does not establish coverage, entitlement or legal compliance.



ACTION PLAN

Write down the next step

Choose the smallest useful next step. Make the request specific enough that the recipient can locate the record and explain or address the exact issue. Keep proof of what you sent and what came back.

The exact issue or request

Evidence IDs and document versions that support the request

Verified recipient and channel

Date sent and follow-up date

What response will resolve the issue, and what still needs professional review

Separate decisions. A courtesy follow-up date is not a legal deadline. A document request does not automatically pause another requirement. Do not sign, settle, move property or disclose sensitive records merely because a box on this page is complete.



REFERENCE GUIDE

Sources and scope

The linked official sources support the educational background. The forms and examples are original organization tools. Sources were checked on October 1, 2026; policies, procedures and law may change. Recheck the current source before relying on a rule.

[1] Centers for Medicare and Medicaid Services

CMS describes the current uninsured/self-pay patient-provider dispute screen, including provider-level excess of at least \$400, a qualifying estimate and a 120-calendar-day initial-bill window. Other listed criteria must also be checked.

<https://www.cms.gov/initiatives/your-patient-rights/medical-bill-rights/get-help/dispute-bill>

[2] Centers for Medicare and Medicaid Services

CMS explains good-faith estimates and patient rights when insurance is not used. This is distinct from protections for insured out-of-network care.

<https://www.cms.gov/initiatives/your-patient-rights/medical-bill-rights/know-your-medical-bill-rights/know-your-medical-bill-rights-when-not-using-insurance>

[3] Centers for Medicare and Medicaid Services

CMS identifies the patient-provider dispute resolution process and provider-level estimate comparison; current official instructions should control submission requirements.

<https://www.cms.gov/initiatives/no-surprise-billing/overview/policies-resources/providers-payment-resolution-patients>

Keep the scope clear

Scheduled uninsured/self-pay workflow; emergency care must not be delayed

No guarantee an informal quote is a qualifying estimate

Do not universalize a threshold or filing date without checking all current requirements

Not an insured benefit appeal or provider-plan arbitration guide