CHILDREN'S MEDICAL SERVICES (CMS) PROGRAM

ESTIMATE OF CHARGES FORM

Date Completed: ____________________ **Admission Date:** ____________________

Patient Name: ____________________ **Est. Procedure Time:** ____________________

Patient DOB: ____________________ **Patient Type: *** ____________________

***(inpatient or outpatient)**

Diagnosis: ____

Procedure: ____

Med/Surgical Services: ____

LOS: ____

CPT Code(s): ____

I. ESTIMATED HOSPITAL CHARGES

* Operating Room $ ____________________
* Recovery Room $ ____________________
* Room Rate $ ____________________
* Miscellaneous Charges $ ____________________

Subtotal $ ____________________

II. ESTIMATED PROFESSIONAL FEES (based on CPT(s) listed above)

* Attending Physician $ ____________________
* Anesthesia Fees $ ____________________

Subtotal $ ____________________

TOTALS $ ____________________

Include this form with your pre-authorization request.
If requested, Email the Completed Form and Treatment Plan to mdh.childrensmedicalservices@maryland.gov
If requested, Fax the Completed Form and Treatment Plan to (443) 275-5434

*Please be reminded that these are only estimates and do not reflect any actual charges or take into consideration charges related to services rendered due to unexpected complications during this course of treatment.

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