

# Patient Responsibility Estimates FAQs

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## How do you satisfy the “No Surprises Act” in CollaborateMD?

The No Surprises Act has many provisions. The Patient Estimates feature allows you to easily create Good Faith Estimates as required by the act. An NSA-compliant GFE has the following features:

1. The estimate must include the items, fees, or services that are reasonably expected to be provided. Items or services must be included in the GFE even if the individual will receive the items and services from another provider or another facility.
  1. In CollaborateMD, you'll create the Estimate at the time that the appointment is scheduled. At that time, you'll enter the expected items or services by CPT/HCPCS/Revenue code for the services that are included in the estimate.
2. The estimate must be provided to the patient upon request (within one business day).
  1. In CollaborateMD, you'll send the estimate to the customer by either printing the estimate and handing it to the patient, printing the estimate and saving the PDF to send directly to the patient or sending the estimate electronically via the Statement option, which will link the patient to the Payment Portal where their full estimate is available.
3. If there are any changes to the estimate, the updated estimate must be provided to the patient within one business day of the scheduled appointment.
  1. In CollaborateMD, you'll create a new estimate and send it as described above. When a new estimate is created, the previous estimate is automatically marked as a "previous estimate" which will not appear in the payment portal.
4. The estimate must include the following information: Patient name & date of birth, description of the primary service with the date if applicable, the diagnosis description and code, a list of other services, the expected charges associated with each service, and the name, NPI, and Tax ID of each provider or facility, as well as the location of any office or facility locations where the items are expected to be furnished. Additionally, the estimate must include a disclaimer that notes that there may be other services that are recommended but not included in the estimate, that the information provided in the estimate is only an estimate, that the estimate is not a contract requiring the individual to obtain the services, and that the individual has the right to initiate a dispute process if the actual billed charges are substantially higher than the estimated amounts, including directions on how to initiate that process.
  1. In CollaborateMD, you will list the services (with the primary service first) when creating an estimate from an appointment (or list the services in the Charges tab when creating an estimate from a claim). When you print an estimate, or when a patient prints an estimate from the Paymer Portal, the required information and disclaimer are automatically included, using the information on the appointment or claim to correctly fill out the provider, facility, and office information.

## How do I use the Patient Estimates feature to collect Copay before the visit?

Within the appointment for the visit, create a new Estimate. Fill in the services if necessary (they will fill automatically from the patient defaults) and choose one of the following options:

1. **Quick Estimate:** If the patient's Copay is set on the Insurance Policy (check the Patient -> Insured tab within the appointment), then Quick Estimate is available. This will quickly create an estimate based on the patient's copay amount.
2. **Auto Estimate:** If the patient's Copay is not set, or may be out of date, Auto Estimate will automatically determine the right copay based on the patient's insurance policy. If the patient has multiple copays (for example, one copay for specialists and one for their primary care provider), the system will select the right copay based on the appointment resource Provider's taxonomy code, and you can change that selection before confirming the estimate.

Once the estimate is created, it will automatically appear in the Payment Portal (if available). Mark the estimate as Due if it isn't already.

Then, you can immediately send a Text or Email estimate statement to the patient, which will tell them that their copay is due and direct them to the Payment Portal, where they can pay their Copay, even if the patient doesn't have a Payment Portal account!

## What is the Contract Amount and how do I enter this information?

The contract amount is recommended in order to create an accurate estimate. It represents the expected Allowed amount for the service.

To enter contract amounts, go to Customer Setup -> Codes -> Contracts. You can import actual contract in Excel format, or you can estimate your contracts using the actual allowed amounts from recent charges.

The contracted amount isn't needed if the patient is Self Pay (the estimate is based on the total charge amount). If a contract amount is not in place, the system will automatically determine a reasonable price from recent Allowables when possible. If there aren't any recent allowables, the Quick Estimate option is always available to produce an estimate based on the patient's Copay amount.

## What is an Auto Estimate?

The Auto Estimate feature works directly with the payer's eligibility system to determine the patient's amount due based on the services and the latest plan information about remaining deductibles and other limitations.

An auto estimate may return multiple results, available from the dropdown menu in the Estimate Dialog.

1. A common occurrence is to receive a result for In-Network and Out-of-Network benefits. You can set whether you are in-network or out-of-network in the Payer section to have the system automatically select the right benefits for your network status.
2. Another common occurrence is to receive a result for Specialist and Primary Care Provider copayments. The system will try to use your provider taxonomy code to select the right plan copayment if possible, but you can always choose a different estimate.

3. For some services, the plan may have many different benefits that apply to similar services. For example, a colonoscopy may be covered as a preventative service with no patient responsibility, while similar services may not be covered in the same way. The system can't take into account every plan or service detail, and therefore it will usually not automatically detect the right estimate. Instead, the system will show you all of the possible estimates so that you can select the estimate that best meets the planned services.

The Auto Estimate service is not ready to provide accurate estimates for Inpatient hospital visits or Skilled Nursing services. At this time, if you ask for an auto estimate for one of these services, you will see the message "Patient estimation for Inpatient and Skilled Nursing is not yet available."

**DISCLAIMER:** The information provided by this tool is not a guarantee of coverage, a guarantee of payment, or authorization for a particular service. Estimates are based on current plan information provided by the payer's real-time eligibility response, which may not reflect all of the terms, conditions, limitations, and exclusions that may apply to the patient's coverage and do not include pending claims that have not been entered into the payer's adjudication system. The estimates provided by this tool are not an exact calculation of actual costs. Actual costs will vary depending on the specifics of the patient's benefit plan and the particular services received.

## What if the estimated amount is \$0.00?

The estimated amount may be \$0.00 if the patient's remaining deductible is \$0.00 and the coinsurance amount is 0%, if the patient's remaining out-of-pocket limitation for the year is \$0.00, or if the service is a covered preventative service.

At this time, \$0.00 estimates can be saved and printed, but will not show in the Payment Portal and the statement feature is not currently available.

## Can I edit the amount due for an estimate?

Estimates, once created, cannot be edited. If the estimate is incorrect, please create a new estimate. Payments (if any) are automatically transferred to the "official" estimate.

## Does the electronic statement need to be configured in order to send the statement from the "Estimate" screen?

Statements can be printed from the Estimate screen if you do not have electronic statements enabled. But if you want to send SMS or Email estimates, then you must have Electronic Statements enabled.

## What is the "No Surprises Act"?

The No Surprises Act has many new requirements that providers must follow to help protect patients from

surprise medical bills.

One of those requirements is that providers and facilities must give a Good Faith Estimate (GFE) to uninsured (or self-pay, including insured patients who will not be using their insurance) patients on scheduling or upon the patient's request.

## How do I delete an estimate?

If you made a mistake when creating an Estimate, click the Delete button to remove the estimate. You can also create a new Estimate, which will automatically delete the previous Estimate.

If you accidentally delete an Estimate, you can find it under Previous Estimates. Expand the Previous Estimates and select Make Official Estimate to un-delete the Estimate. Note that any current estimate will be deleted if you do this – each appointment or claim can only have one related Estimate.

## What are the requirements to use Patient Estimates?

The following are the requirements to use the estimates feature:

1. **Patient Eligibility** (Real-Time Eligibility) must be enabled
  2. The feature is included in **Plan 4 Ultimate Service**
  3. **Plans 2 and 3** can use it at a cost of **\$.31** per estimate
  4. The feature is **Not available in Plan 1**
  5. **Billing services** can enable and use the feature at a cost of **\$.31** per estimate
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