Request for Estimates

This form will be utilized for patients to make a request for an estimate of medical services. Utilizing this form will assist by making the process more efficient, and allow Parrish Medical Center to efficiently track your request. Please complete the form in its entirety, by submitting the requested information. If you are not the patient requesting the information (except on the behalf of a minor) you will need a Power of Attorney at the time of submission of this document or a Release of Information form.

Request for an estimate of charges are for hospital services only. The estimate does not include the reading or interpretation of the examination, which may be required. This is a good faith estimate based on the current Charge Master, and an average of previous procedures performed at Parrish Medical Center.

Procedure: (Please submit copy of physician order):

____

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Person submitting the request / Date: ____

Patient Name: ____

Address: ____

City: ______________________ State: _________________ Zip Code: ___________________

Phone: (______) ________________________________

Age of Patient: _________________________

Physician:______________________________ Dr.'s Phone Number: ________________________

Patient Signature: _____________________________________ Date: ______________________

***************************TO BE COMPLETED BY PMC*************************

Person submitting charges: ________________________________ Ext:__________________

**Estimated Cost: $________________ Date returned to patient: ________________________

Tracking Number: _______________________________________

Forward Immediately to: Judy Persichini
Business Office North Building
Parrish Medical Center
951 North Washington St.
Titusville, Fl 32796