FUKUJI & LUM
PHYSICAL THERAPY

GOOD FAITH ESTIMATE FOR HEALTH CARE ITEMS & SERVICES

PATIENT		
FIRST NAME	MIDDLE NAME	LAST NAME
DATE OF BIRTH: _____/_____/ _____		
PATIENT IDENTIFICATION NUMBER:		
PATIENT MAILING ADDRESS, PHONE NUMBER, & EMAIL ADDRESS		
STREET OR P.O. BOX		APARTMENT
CITY	STATE	ZIP CODE
PHONE		
EMAIL ADDRESS		
CONTACT PREFERENCE: [ ] BY MAIL [ ] BY EMAIL		
PATIENT DIAGNOSIS		
PRIMARY SERVICE OR ITEM REQUESTED/SCHEDULED		
PRIMARY DIAGNOSIS		PRIMARY DIAGNOSIS CODE

FUKUJI & LUM
PHYSICAL THERAPY

SECONDARY DIAGNOSIS	SECONDARY DIAGNOSIS CODE
IF SCHEDULED, LIST THE DATE(S) THE PRIMARY SERVICE OR ITEM WILL BE PROVIDED: [ ] CHECK THIS BOX IF THIS SERVICE OR ITEM IS NOT YET SCHEDULED	
DATE OF GOOD FAITH ESTIMATE: _____/_____/ _____	
PROVIDER NAME	ESTIMATED TOTAL COST $100 / 1 HOUR VISIT
PROVIDER NAME	ESTIMATED TOTAL COST
PROVIDER NAME	ESTIMATED TOTAL COST
TOTAL ESTIMATED COST: $_____	

FUKUJI & LUM PHYSICAL THERAPY ESTIMATE

FUKUJI & LUM PHYSICAL THERAPY					
STREET ADDRESS: 407 Uluniu Street, Suite 301					
CITY: Kailua		STATE: HI		ZIP CODE: 96734	
CONTACT PERSON: Brad Kaya		PHONE: 808-261-4321		EMAIL: Malama@fukujilumpt.com	
NATIONAL PROVIDER IDENTIFIER				TAXPAYER IDENTIFICATION NUMBER	

DETAILS OF SERVICES AND ITEMS FOR FUKUJI & LUM PHYSICAL THERAPY

SERVICE/ITEM	ADDRESS WHERE SERVICE/ITEM WILL BE PROVIDED	DIAGNOSIS CODE	SERVICE CODE	QUANTITY	EXPECTED COST
	[STREET, CITY, STATE, ZIP]	[ICD CODE]	[SERVICE CODE NUMBER]		

TOTAL EXPECTED CHARGES FROM FUKUJI & LUM PHYSICAL THERAPY $
ADDITIONAL NOTES: