Healthy Blue

Medicaid Managed Care

Form D: Billing Summary Form Bone Marrow/Stem Cell Transplant

Initial form ☐ Additional form ☐ Revised form ☐		Date revised:	
Patient name:		ID number:	
DOB:			
Transplant hospital:			
Payment address:			
Transplant type:	Autologous ☐ Allogeneic ☐ "Mini" Allogeneic ☐ Tandem #1 ☐ Tandem #2 ☐ Peripheral stem cells ☐ Bone Marrow ☐ Cord Blood ☐ Related ☐ Unrelated ☐ Matched ☐ Mismatched ☐		

Pre-transplant period dates/charges		
Pre-transplant (inpatient) dates:		
	to:	
Inpatient pre-transplant rate if applicable		
Hospital charges:	$	
Professional charges:	$	
Total billed charges:	**$**	
Case rate/amount due		
Per diem rate:	$	
or		% of charges
Lesser of		% of charges
Other:		
Pre-transplant period amount due:		
$		
*Total adjustments (attach itemization and/or claims):		
$		
Pre-transplant period total adjusted amount due:		
$		
Mobilization/harvesting dates/charges		
Mobilization therapy dates:		
IP:		
OP:		

Mobilization total billed charges:		
Hospital:	$	
Professional:	$	
Harvesting dates:		
IP:		
OP:		
Harvesting total billed charges: (for unrelated donors, i.e., NMDP charges)		
Hospital:	$	
Professional:	$	
Case rate dates/charges		
Case rate period dates:		
	to:	
Marrow ablative therapy (or preparative regimen date(s):		
IP:		
OP:		
Transplant date:		
Hospital charges:	$	
Professional charges:	$	
Ancillary charges:	$	
Total billed charges: (Inc. any mobilization/harvesting charge above)	**$**	
Case rate/amount due		
Case rate amount:	$	
Lesser of		% of charges
Other:		
Case rate period amount due: *(Inc. any mobilization/harvesting charge above)*		
$		

*Total adjustments (attach itemization and/or claims):		
$		
Case rate period total adjusted amount due:		
$		
Outlier period dates/charges		
Outlier (inpatient) dates:		
	to:	
Hospital charges:	$	
Professional charges:	$	
Total billed charges:	**$**	
Case rate/amount due		
Per diem rate:	$	
or		% of charges
Lesser of		% of charges
Other:		
Outlier period amount due:		
$		
*Total adjustments (attach itemization and/or claims):		
$		
Outlier period total adjusted amount due:		
$		

Hospital: *A separate form must be completed for each transplant. Copies of all claims for the dates of service noted above and included in the case rate(s) agreement must be attached. *Total adjustments may include, for example, payor prior payments for services included in the case rate(s) agreement.*					
Form completed by (print):		Phone:		Date:	
Plan contact (print name):					

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