Healthy Blue | HERITAGE HEALTH

Form C: Billing Summary Form — Solid Organ Transplant

Initial form ☐ Additional form ☐ Revised form ☐	Date revised:	

Patient name:		ID number:	
DOB:			
Transplant hospital:			
Payment address:			
Transplant type:	Initial transplant ☐ Re-transplant ☐ Cadaveric ☐ Living donor ☐		

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:		
$		

Case rate period dates/charges		
Case rate period dates:		
	to:	
Transplant date:		
Inpatient discharge date(s):		
Readmission date(s):		
Organ procurement charges		
Hospital charges:	$	
Professional charges:	$	
Ancillary charges:	$	
Total billed charges:	**$**	
Case rate/amount due		
Applicable rate:		
Case rate amount:	$	
Lesser of		% of charges
Other:		
Case rate period amount due:		
$		
* 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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