UniCare
An Anthem Company

Form C: Billing Summary Form Solid Organ Transplant

Initial Form ☐ Additional Form ☐ Revised Form ☐ Date Revised:________________

Patient Name **ID #** **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 e.g., Payor prior payments for services included in the Case Rate(s) agreement.

Form Completed by
(Plan Contact - Print Name) ____________ Phone ____________ Date ____________