UNICARE
An Anthem Company

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

Initial Form ☐ Additional Form ☐ Revised Form ☐ Date Revised:_____

Patient Name **ID #** **DOB**

Transplant Hospital

Payment Address

Transplant Type (check all that apply):
Autologous ☐ Tandem #2 ☐ Related ☐
Allogeneic ☐ Peripheral stem cells ☐ Unrelated ☐
"Mini" Allogeneic ☐ Bone Marrow ☐ Matched ☐
Tandem #1 ☐ Cord Blood ☐ 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 date(s):
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: $ _____
Professional: $ _____
Ancillary Charges: $_____
Total Billed Charges:
$ _____
(Inc. any applicable mobilization/harvesting charge above)

MOBILIZATION / HARVESTING DATES / CHARGES *(continued)*

CASE RATE / AMOUNT DUE

- Case Rate Amount $ _____
- Lesser of _____% of charges
- Other: _____

Case Rate Period Amount Due: (inc. any applicable 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:
$ _____

TOTAL ADJUSTED AMOUNT DUE FROM THE PLAN: $ _____

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 _____