

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

Tandem #2 □

Date revised: ID number:

Highmark Blue Cross Blue Shield of Western New York (Highmark BCBSWNY) partners with Amerigroup companies to administer certain services to Medicaid Managed Care (MMC) and Child Health Plus (CHPlus) members. Please note, this information is specific to MMC and CHPlus programs only.

onal form □ Revised form		Date revise	
		ID number:	
_	=	#1 ☐ Tane Matched ☐ Misr	
iod dates/charges	Hospital: \$		
nt) dates:	Harvesting dates:		
t rate if applicable	Harvesting total billed charge (for unrelated donors, i.e., N		
\$	Hospital: \$		
Ψ	Professional: \$		
\$	Case rate dates/charges		
e	Case rate period dates:		
Ι Ψ	to:		
mount due		reparative	
	IP:		
	OP:		
% of charges	Transplant date:		
% of charges	Hospital charges: \$		
70 Of Charges		\$	
	+	_	
mount due:	Total billed charges: (Inc. any mobilization/harvesting charge above)	\$	
ach itemization and/or	Case rate/amount	due	
don itomization and/or	Case rate amount: \$		
	Lesser of	% of charges	
total adjusted	Other:	_	
	Case rate period amount due:		
		ng charge	
ting dates/charges	\$		
ntes:			
	Autologous Allog Marrow Cord Blood iod dates/charges nt) dates: t rate if applicable	Autologous Allogenic Mini" Allogenic Antologous Allogenic Marrow Marrow Allogenic Melated Unrelated iod dates/charges	

Hospital:		\$				
Profession	nal:	\$				
Harvestin	Harvesting dates:					
IP:						
OP:						
Harvestir (for unrel				es: IDP charges)		
Hospital:		\$				
Profession	nal:	\$				
Case rate	dates/c	harge	s			
Case rate	period d	ates:				
		to:				
Marrow ablative therapy (or preparative regimen date(s):						
IP:						
OP:						
Transplan	nt date:					
Hospital c	harges:		\$			
Profession	nal charg	jes:	\$			
Ancillary of			\$			
Total bille (Inc. any mobilization charge ab	on/harve			\$		
	Case ra	ite/am	ount d	lue		
Case ra	ate amou	nt:	\$			
Lesser	of			% of charges		
Other:						
Case rate (Inc. any i above)				g charge		
*Total adj	ustments	(attac	ch item	ization and/or		

ned □					
\$					
Case rate period total adjusted amount due:					
\$					
Outlier period dates/charges					
Outlier (inpatient) dates:					
	to:				
Hospital charges:	Hospital charges:				
Professional charge	Professional charges:		\$		
Total billed charge	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:					
\$					

Peripheral stem cells ☐ Bone

https://providerpublic.mybcbswny.com

Mobilization total billed charges:

Amerigroup Partnership Plan, LLC provides management services for Highmark Blue Cross Blue Shield of Western New York's managed Medicaid. Amerigroup Partnership Plan, LLC brinda servicios administrativos para Medicaid administrado de Highmark Blue Cross Blue Shield of Western New

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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):						