HIGHMARK WESTERN NEW YORK

Medicaid Managed Care
Child Health Plus

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

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.

Initial form ☐ Additional form ☐ Revised form ☐		Date revised:	
Patient name:		ID number:	
DOB:			
Transplant hospital:			
Payment address:			
Transplant type:	Autologous ☐ Allogenic ☐ "Mini" Allogenic ☐ 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:		
$		

https://providerpublic.mybcbswny.com

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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):					