

Form C: Billing Summary Form — Solid Organ Transplant

Highmark Blue Cross Blue Shield of Western New York 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

		CHPlus programs	only.	143 (0111		i louse flote, ti		4.101110	
Initial form □ Additional form □ Re			vised form □		Date revised:				
Patient name:					ID number:				
DOB:									
Transplant hos	pital:								
Payment addre	ess:								
Transplant type:		Initial transplant	Re-transplant □	Cadaverio	: □ Living d	onor 🗆			
Pre-transplan	t perio	d dates/charges	Case rate period dates/charges		arges	Outlier period dates/charges			
Pre-transplant (inpatient) dates:				Case rate period dates:			Outlier (inpatient) dates:		
	to:		Transplant date:				to:		
Inpatient pre-transplan applicable		nt rate if	Inpatient discharge date(s):			Hospital charge	es: \$		
Hospital charge	es:	\$	Readmission			Professional charges:	\$		
Professional charges:		\$	date(s): Organ procurement	t charges		Total billed charges:	\$		
Total billed charges:		\$	Hospital charges: \$			Case rate/amount due			
Case rate/amount due			Professional charges:	4		Per diem rate: \$			
Per diem	\$		Ancillary charges:	\$		or		% of	
rate:	<u> </u>	% of	Total billed charges:	\$		Lesser of		charges % of	
01		charges % of	Case rate/amount due		е			charges	
Lesser of		charges Applicable rate:				Other:			
Other:		Case rate amount: \$ Outlier period		Outlier period a	mount du	e:			
Pre-transplant period amount due:			Lesser of	% of cha	arges	\$			
\$			Other:	Other:		* Total adjustments (attach			
* Total adjustments (attach itemization			Case rate period am	Case rate period amount due:		itemization and/or claims):			
and/or claims):			\$	·		\$			
\$			* Total adjustments (and/or claims):	* Total adjustments (attach itemization and/or claims):		Outlier period total adjusted amount due:			
Pre-transplant period total adjusted amount due:			\$	\$			\$		
\$			· ·	Case rate period total adjusted amount due:					
Ψ			\$						
Hospital: A so	narata	form must be comple	eted for each transplant. Co	onies of al	I claims for the c	lates of service n	oted abou	ve and	
			st be attached. *Total adju						
services includ	led in th	ne case rate(s) agree	ment.						

https://providerpublic.mybcbswny.com

Form completed by (print):

Plan contact (print name):

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 York

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NYWPEC-3602-22 February 2022

Phone:

Date: