Wellmark®

ATTACHMENT H
Blue Distinction® Centers for Transplant (BDCT)
INSTITUTION BILLING SUMMARY FORM

Bone Marrow/Stem Cell and Solid Organ Transplant

Patient Name:_____ Wellmark Patient ID#:_____ Date of Birth: _____/_____/_____

Transplant Center:_____ Payment Address:_____

Patient Account Number:_____ Contact Name:_____

Contact Email Address:_____ Contact Phone#:(_____)_____

TRANSPLANT TYPE: (please check all that apply)

BONE MARROW/STEM CELL **Patient Diagnosis:**_____

Type:	☐ Autologous	☐ Allogeneic	☐ "Mini" Allogeneic	☐ Tandem: #1	☐ Tandem: #2
	☐ Sequential	☐ 1	☐ 2	☐ 3	☐ 4
Cell Source:	☐ Bone Marrow	☐ Peripheral Blood Stem Cell	☐ Cord Blood Single Unit	☐ Cord Blood Multiple Units	
Donor (If Allogeneic):	☐ Related	☐ Unrelated	☐ Matched	☐ Mismatched	

SOLID ORGAN **Patient Diagnosis:**_____

Organ Type:_____ ☐ Initial Transplant ☐ Re-transplant **Donor:** ☐ Deceased ☐ Living Donor

PRE-TRANSPLANT PERIOD DATES/CHARGES

Pre-Transplant Period (Inpatient) Dates: _____/_____/_____ to _____/_____/_____

(Complete the following section only if a BDCT Inpatient Pre-Transplant Rate is applicable)

Hospital Charges: $_____ Professional Charges: $_____ **Total Billed Charges:** $_____

PRE-TRANSPLANT RATE/AMOUNT DUE

- Per Diem Rate $_____ or _____% of Charge
- Lesser of _____ % of Charges
- Other_____

Pre-Transplant Rate Amount Due: $_____

* Total Adjustments (attach itemization and/or claims): $_____

Pre-Transplant Rate Total Adjustment Amount Due: $_____

MOBILIZATION AND HARVESTING DATES/CHARGES - *Complete this section for Bone Marrow or Stem Cell Transplant*

Mobilization Therapy Date(s):

Inpatient: _____/_____/_____, _____/_____/_____ Outpatient: _____/_____/_____, _____/_____/_____

Marrow Ablative Therapy (or Preparative Regimen Date(s):

Inpatient: _____/_____/_____, _____/_____/_____ Outpatient: _____/_____/_____, _____/_____/_____

Mobilization Total Billed Charges:

Hospital Charges: $_____ Professional Charges: $_____

Harvesting Date(s):

Inpatient: _____/_____/_____, _____/_____/_____ Outpatient: _____/_____/_____, _____/_____/_____

Harvesting Total Billed Charges: (For Unrelated Donors, i.e., NMDP Charges)

Hospital Charges: $_____ Professional Charges: $_____

GLOBAL PERIOD DATES/CHARGES

Global Period Date(s): _____/_____/_____ to _____/_____/_____

Transplant Date(s): _____/_____/_____, _____/_____/_____

Inpatient Discharge Date(s): _____/_____/_____, _____/_____/_____ Readmission Date(s): _____/_____/_____, _____/_____/_____

Organ Procurement Charges: $_____ Hospital Charges: $_____ Professional Charges: $_____

Ancillary Charges: $_____

Total Billed Charges: $_____ (Include any applicable mobilization/harvesting charge above)

GLOBAL RATE/AMOUNT DUE

- Global Rate $_____
- Lesser of _____ % of Charges
- Other_____

Global Rate Amount Due: $_____

* Total Adjustments (attach itemization and/or claims): $_____

Global Rate Total Adjustment Amount Due: $_____

OUTLIER PERIOD DATES/CHARGES - *Complete this section if a BDCT Inpatient Outlier Period is applicable*

Outlier Period (Inpatient) Date(s): _____/_____/_____ to _____/_____/_____

Hospital Charges: $_____ Professional Charges: $_____ **Total Billed Charges:** $_____

OUTLIER RATE/AMOUNT DUE

- Per Diem Rate $_____ or _____% of Charge
- Lesser of _____ % of Charges
- Other_____

Outlier Rate Amount Due: $_____

* Total Adjustments (attach itemization and/or claims): $_____

Outlier Rate Total Adjustment Amount Due: $_____

LAST SERVICE DATE IN BUNDLED CLAIM PACKET: _____/_____/_____

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 BDCT Global Rate(s) agreement must be attached.*

Total adjustments *may include e.g., Payor prior payments for services included in the BDCT Global Rate(s) agreement.*

You may fax this form (including any adjustments) to the BDCT Transplant Alert Team at 515-376-9074 or mail to Wellmark Blue Cross and Blue Shield of Iowa, Mail Station 5E296, PO Box 9232, Des Moines, IA 50306-9232.

Required Federal Accessibility and Nondiscrimination Notice

Discrimination is against the law

Wellmark complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Wellmark does not exclude people or treat them differently because of their race, color, national origin, age, disability or sex.

Wellmark provides:

- Free aids and services to people with disabilities so they may communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call 800-524-9242.

If you believe that Wellmark has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Wellmark Civil Rights Coordinator, 1331 Grand Avenue, Station 5W189, Des Moines, IA 50309-2901, 515-376-4500, TTY 888-781-4262, Fax 515-376-9073, Email CRC@Wellmark.com. You can file a grievance in person, by mail, fax or email. If you need help filing a grievance, the Wellmark Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail, phone or fax at: U.S. Department of Health and Human Services, 200 Independence Avenue S.W., Room 509F, HHH Building, Washington DC 20201, 800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: Si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Comuníquese al 800-524-9242 o al (TTY: 888-781-4262).

注意：如果您说普通话，我们可免费为您提供语言协助服务。请拨打 800-524-9242 或（听障专线：888-781-4262）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Xin hãy liên hệ 800-524-9242 hoặc (TTY: 888-781-4262).

NAPOMENA: Ako govorite hrvatski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte 800-524-9242 ili (tekstualni telefon za osobe oštećena sluha: 888-781-4262).

ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen kostenlose sprachliche Assistenzdienste zur Verfügung. Rufnummer: 800-524-9242 oder (TTY: 888-781-4262).

تنبيه: إذا كنت تتحدث اللغة العربية، فإننا نوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 800-524-9242 أو (خدمة الهاتف النصي: 888-781-4262).

ສ່ຽງຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາ ໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ຕິດຕໍ່ຫາ. (TTY: 888-781-4262.)

주의: 한국어 를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 800-524-9242번 또는 (TTY: 888-781-4262)번으로 연락해 주십시오.

ध्यान रखें : अगर आपकी भाषा हिन्दी है, तो आपके लिए भाषा सहायता सेवाएँ, नि:शुल्क उपलब्ध हैं। 800-524-9242 पर संपर्क करें या (TTY: 888-781-4262)।

ATTENTION : si vous parlez français, des services d'assistance dans votre langue sont à votre disposition gratuitement. Appelez le 800 524 9242 (ou la ligne ATS au 888 781 4262).

Geb Acht: Wann du Deitsch schwetze duscht, kannscht du Hilf in dei eegni Schprooch koschdefrei griege. Ruf 800-524-9242 odder (TTY: 888-781-4262) uff.

โปรดทราบ: หากคุณพูด ไทย เรามีบริการช่วยเหลือด้านภาษาสำหรับคุณโดยไม่คิดค่าใช้จ่าย ติดต่อ 800-524-9242 หรือ (TTY: 888-781-4262)

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyong tulong sa wika na walang bayad. Makipag-ugnayan sa 800-524-9242 o (TTY: 888-781-4262).

တၢ်နုးသ့ဉ်ညါ–နမ့ၢ်ကတိၤကညီကျိာ်.ကျိာ်တၢ်မၤစၢၤတၢ်ဖံးတၢ်မၤတဖဉ်.လၢတဘဉ်လာ်ဘူးလဲ.ဆိဉ်လၢနဂီၢ်လီၤ.ဆဲးကျိုးဆူ ၈၀၀–၅၂၄–၉၂၄၂မ့တမ့ၢ်(TTY:၈၈၈–၇၈၁–၄၂၆၂)တက့ၢ်.

ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь 800-524-9242 (телетайп: 888-781-4262).

सावधान: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंका लागि नि:शुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध गराइन्छ। 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्क गर्नुहोस्।

ማሳሰቢያ: አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ እገዛ አገልግሎቶች፣ ከክፍያ ነፃ፣ ያገኛሉ። በ 800-524-9242 ወይም (በTTY: 888-781-4262) ይሙሉ ያነጋግሩን።

HEETINA To a wolwa Fulfulde laabi walliinde dow wolde, naa e njobdi, ene ngoodi ngam maaɗa. Heɓir 800-524-9242 malla (TTY: 888-781-4262).

FUULEFFANNAA: Yo isin Oromiffaa, kan dubbattan taatan, tajaajiloonni gargaarsa afaanii, kaffaltii malee, isiniif ni jiru. 800-524-9242 yookin (TTY: 888-781-4262) quunnamaa.

УВАГА! Якщо ви розмовляєте українською мовою, для вас доступні безкоштовні послуги мовної підтримки. Зателефонуйте за номером 800-524-9242 або (телетайп: 888-781-4262).

Ge': Diné k'ehjí yáníłti'go níká bizaad bee áká' adoowoł, t'áá jiik'é, náhóló. Kojį' hólne' 800-524-9242 doodaii' (TTY: 888-781-4262)

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