YH26-0001 Exhibit B - AHCCCS Transplant Invoice and Instructions

CONTRACTOR FACILITY NAME _____
FACILITY ADDRESS _____
CITY, STATE ZIP _____

CONTRACTOR CONTACT NAME _____
CONTACT INFORMATION _____
SUPERVISOR CONTACT _____

AHCCCS TRANSPLANT INVOICE

DO NOT SEPARATE

BILL TO: AHCCCS or Plan			
DATE BILLED	**AUTHORIZATION**	**DATES COVERED**	**CONTRACTOR ID**

MEMBER NAME	MEMBER ID	COMPONENT BILLED	TOTAL BILLED

BILLED CHARGES DETAILED

	NUMBER OF CLMS BILLED WITH PACKET	TOTAL BILLED CHARGES BY FORM TYPE
INPATIENT	_____	$ _____
OUTPATIENT	_____	$ _____
PROF FEES	_____	$ _____

EXPECTED PAYMENT $

PLEASE REMIT PAYMENT TO:
****Include only if different from billing facility**

FACILITY NAME
FACILITY ADDRESS
CITY, STATE ZIP
CONTACT NAME

*****All Hospital, physician, and professional billing are to be included on this invoice.*****

See Section 9 of the Scope of Work for submission instructions.

CONTRACTOR FACILITY
FACILITY ADDRESS
CITY, STATE ZIP

HOSPITAL BILLING FACILITY

TRANSPLANT FACILITY ADDRESS

CONTRACTOR CONTACT NAME
CONTACT INFORMATION

BILLING PERSON'S PHONE #, FAX# AND EMAIL ADDRESS

SUPERVISOR CONTACT

SUPERVISOR CONTACT PHONE, FAX AND EMAIL ADDRESS NEEDED IN THE EVENT THAT BILLING CONTACT CANNOT BE REACHED

TRANSPLANT INVOICE INSTRUCTIONS

DO NOT SEPARATE

BILL TO: AHCCCS or Plan

Either AHCCCS or Plan Address

DATE BILLED	AUTHORIZATION	DATES COVERED	CONTRACTOR ID
Date mailed to AHCCCS	Authorization # Given to facility from Med Mgmt	Begin and end dates when actual services were performed-verify services are within date authed date span	AHCCCS Contractor ID
MEMBER NAME	**MEMBER ID**	**COMPONENT BILLED**	**TOTAL BILLED**
Name of Transplant recipient	Recipient's AHCCCS ID#	Transplant Component being billed-IE: MUD, Prep and Trans, 1-30 etc.	Total of ALL billed charges: IP UB's + OP UB's + 1500's

BILLED CHARGES DETAILED

Number of Inpatient claims billed in packet

Number of outpatient claims billed in packet

Number of 1500's (HCFA) claims billed in packet

	NUMBER OF CLAIMS BILLED WITH PACKET	TOTAL BILLED CHARGES BY FORM TYPE
INPATIENT	_____	$ _____
OUTPATIENT	_____	$ _____
PROF FEES	_____	$ _____

Total charges for Inpatient claims billed with packet

Total charges for all Outpatient claims billed with packet

Total charges for all 1500's(HCFA's) billed with packet

EXPECTED PAYMENT $

Payment expected for component per AHCCCS facility contract

PLEASE REMIT PAYMENT TO:
**Include only if different from billing facility

FACILITY NAME
FACILITY ADDRESS
CITY, STATE ZIP
CONTACT NAME

This information is ONLY required if payment is to be remitted to another facility other than billing facility

See Section 9 of the Scope of Work for submission instructions.