



Schedule of Hospital Charges

Blue Cross and Blue Shield of Illinois

Operating not-for-profit

Blue Cross Plan for Hospital Care

300 East Randolph Street

Chicago, IL 60601

Date _____

Hospital _____

Address _____ City _____

| | | | | | |
|----|---------------------|-------------|---------------------------|---------|-------------|
| 1. | ROOM CHARGES | | DAILY RATE PER BED | | |
| | Room Capacity | No. of Beds | Minimum | Maximum | Most Common |
| | Single | _____ | _____ | _____ | _____ |
| | Two Beds | _____ | _____ | _____ | _____ |
| | Three Beds | _____ | _____ | _____ | _____ |
| | Four Beds | _____ | _____ | _____ | _____ |
| | Five or More Beds | _____ | _____ | _____ | _____ |

ROOM CHARGES-SPECIAL DEPARTMENTS

Pediatric Service

| | | | | |
|------------------|-------|-------|-------|-------|
| Single | _____ | _____ | _____ | _____ |
| Two or More Beds | _____ | _____ | _____ | _____ |

Psychiatric Service

| | | | | |
|------------------|-------|-------|-------|-------|
| Single | _____ | _____ | _____ | _____ |
| Two or More Beds | _____ | _____ | _____ | _____ |

Other Special Services (Specify)

| | | | | |
|------------------|-------|-------|-------|-------|
| Single | _____ | _____ | _____ | _____ |
| Two or More Beds | _____ | _____ | _____ | _____ |

2. **NURSERY CHARGES**

Number of Bassinets _____

Charge per Day for Newborn during Mother's Stay _____

Charge per Day for Newborn after Mother Leaves _____

Additional Charge for Incubator per Day _____

3. **LABORATORY CHARGES**

Routine Admission Examinations

Medical Case _____ Surgical Case _____ O.B. Case _____

Pediatric Case _____ Other _____

LABORATORY CHARGES

Subsequent Examinations

C.B.C. _____
R.B.C. _____
W.B.C. _____
Urinalysis _____
Blood Sugar _____
Kahn _____

N.P.N. _____
Blood Sugar _____
Tissue Exam (Microscopic) _____
Blood Typing _____
R.H. Factor _____
Lab Charge for
Blood Transfusion _____

4. TRANFUSION SERVICE CHARGE
Charge for Administration of Blood Transfusion _____

5. OPERATING ROOM CHARGES

Charges Based on Time

Charges Based on Case

Minimum Charge _____
First 1/2 Hour _____
1/2 to 1 Hour _____
1 to 1 1/2 Hours _____
1 1/2 to 2 Hours _____
Maximum Charge _____

| | Minor | Major |
|---------|-------|-------|
| Minimum | _____ | _____ |
| Average | _____ | _____ |
| Maximum | _____ | _____ |

Amount of Charge (if any) for Recovery Room Service _____
Other Charge Basis (if different from above) _____

6. DELIVERY ROOM CHARGES
Specify Basis and Amount of Charge for Delivery Room _____

Amount of Charge (if any) for Use of Labor Room _____

7. ANESTHESIA CHARGES

Charges Based on Time

Charges Based on Case

Minimum Charge _____
First 1/2 Hour _____
1/2 to 1 Hour _____
1 to 1 1/2 Hours _____
1 1/2 to 2 Hours _____
Maximum Charge _____

| | Minor | Major |
|---------|-------|-------|
| Minimum | _____ | _____ |
| Average | _____ | _____ |
| Maximum | _____ | _____ |

If above charge is not applicable, state basis used. _____

Is above charge for materials only? Yes _____ No _____

If "no", on what basis are additional charges made? _____

8. X-RAY CHARGES

What are your charges for the following:

| | |
|----------------------|------------------------|
| Chest_____ | Lower Extremities_____ |
| Upper G.I. _____ | Upper Extremities_____ |
| Colon_____ | Skull_____ |
| Gall Bladder_____ | Abdomen_____ |
| Lumbar Spine_____ | I.V. Pyelogram_____ |
| Pelvis and Hips_____ | |

Radiation Therapy

Give basis and amount of charge for deep therapy_____

Give basis and amount of charge for superficial therapy_____

Give basis and amount of charge for radium therapy_____

Give basis and amount of charge for other therapy (such as isotopes)_____

9. OXYGEN THERAPY

Daily Charge for Use of Oxygen Tent_____

Method and Amount of Charge for Oxygen –

Liter_____ Pound_____ Tank_____ Hour_____

Other_____

10. MISCELLANEOUS

Indicate charges for the following:

Basal Metabolic Rate_____

Electrocardiogram_____

Electro-encephalogram_____

Shock Therapy Treatment (specify type and charge)_____

Emergency Room (Minimum)_____ (Maximum)_____

11. INCLUSIVE RATES

Specify services and charges (if any) in which "inclusive rates" are used:

12. COMMENTS

The above schedule of hospital charges is submitted in accordance with paragraph seven (7) of the Plan – Hospital Contract, and the charges reported above do not exceed the hospital's regularly established charges.

Effective Date

(Authorized Signature)