### 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____________________________________

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1. **ROO.M CHARGES**  
   **DAILY RATE PER BED**

<table>
<thead>
<tr>
<th>Room Capacity</th>
<th>No. of Beds</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Most Common</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Two Beds</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Three Beds</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Four Beds</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Five or More Beds</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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

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2. **NURSERY CHARGES**

<table>
<thead>
<tr>
<th>Number of Bassinets</th>
<th>Charge per Day for Newborn during Mother’s Stay</th>
<th>Charge per Day for Newborn after Mother Leaves</th>
<th>Additional Charge for Incubator per Day</th>
</tr>
</thead>
</table>

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3. **LABORATORY CHARGES**

**Routine Admission Examinations**

- Medical Case________
- Surgical Case________
- O.B. Case________
- Pediatric Case________
- Other________
LABORATORY CHARGES
Subsequent Examinations
C.B.C._________________________________ N.P.N.________________________________
R.B.C._________________________________ Blood Sugar___________________________
W.B.C._________________________________ Tissue Exam (Microscopic)________________
Urinalysis________________________________ Blood Typing___________________________
Blood Sugar______________________________ R.H. Factor_____________________________
Kahn_________________________________ 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_______________ Minor Major
First ½ Hour___________________ Minimum        ___________ __________
½ to 1 Hour___________________ Average         ___________ __________
1 to 1 ½ Hours_________________ Maximum        ___________ __________
1 ½ to 2 Hours_________________ Maximum Charge_______________
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_______________ Minor Major
First ½ Hour___________________ Minimum        ___________ __________
½ to 1 Hour___________________ Average         ___________ __________
1 to 1 ½ Hours_________________ Maximum        ___________ __________
1 ½ to 2 Hours_________________ Maximum Charge_______________
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?__________________________________________________________________________________
### X-RAY CHARGES

What are your charges for the following:

<table>
<thead>
<tr>
<th>Body Part</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest</td>
<td>Lower Extremities</td>
</tr>
<tr>
<td>Upper G.I.</td>
<td>Upper Extremities</td>
</tr>
<tr>
<td>Colon</td>
<td>Skull</td>
</tr>
<tr>
<td>Gall Bladder</td>
<td>Abdomen</td>
</tr>
<tr>
<td>Lumbar Spine</td>
<td>I.V. Pyelogram</td>
</tr>
<tr>
<td>Pelvis and Hips</td>
<td></td>
</tr>
</tbody>
</table>

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) ____________________

### OXYGEN THERAPY

Daily Charge for Use of Oxygen Tent ________________________________________________

Method and Amount of Charge for Oxygen –

<table>
<thead>
<tr>
<th>Liter</th>
<th>Pound</th>
<th>Tank</th>
<th>Hour</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other ______________________________________________________

### MISCELLANEOUS

Indicate charges for the following:

- Basal Metabolic Rate __________________________________________
- Electrocardiogram ____________________________________________
- Electro-encephalogram ________________________________________
- Shock Therapy Treatment (specify type and charge) ______________
- Emergency Room (Minimum) ________ (Maximum) _________________

### INCLUSIVE RATES

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

________________________________________________________________________

________________________________________________________________________

### 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) ____________

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