MAYO CLINIC

Notification

200 First Street SW
Rochester, Mn 55905

ATTN:		Date:	6/23/2015
Company	Maria	Fax:	952-238-0765
No. of Pages	**2+ Any Attachments -- see fax page count for total number of pages**		
Delivery Instructions	**Routine**		
Special Instructions:	Name: **Konarzewski, Mr.Leonardo**		
	MC#: **09-030-806**		
	Certification/Reference#: **Leonardo Konarzewski 9-030-806**		
From	**RST Transplant Financial Services (A)**	Fax:	507-284-5038
		Phone:	507-538-5429

Message:

Attached are the estimates as requested

MAYO CLINIC

TRANSPLANT NOTIFICATION

PATIENT INFORMATION

Clinic Number:	**09-030-806**
Patient's Name:	**Konarzewski, Mr. Leonardo**
Gender:	**Male**
Marital Status:	**Single**
DOB:	**01/03/1994**
Phone:	
Address:	**Street Libia RUA Libia 125**
Address Line 2:	
City, State Zip:	**Porto Alegre, 91370210**

Coordination of Benefits Order

Insurance Information

Order	Insurance Company Name	Insurance ID	Group_Number	Group_Name
INS1	N/A -- Info not available	N/A -- Info not available	N/A -- Info not available	N/A -- Info not available

End of INSURANCE Information

MAYO CLINIC

June 23, 2015

RE: Leonardo Konarzewski
MC#: 9-030-806

Dear Mr. Konarzewski:

Pursuant to the request of your designated representative, Maria Moldonado, please review the attached estimates reflecting the transplant services being requested at Mayo Clinic and the corresponding Pre-Service Deposit (PSD) that would be required prior to scheduling these services.

Included for your review are estimates for the following episode of care per current physician orders, but are not limited to the need for additional medical treatments that may be required:

- Pre-transplant evaluation consults and testing $55,000.00
- Inpatient hospital stay including BEAM conditioning and subsequent autologous peripheral blood stem cell transplant $100,000.00
- Plerixafor/Mozobil mobilization agent (3 doses) $33,000.00
    - *Number of treatments may exceed this amount and will be subject to additional charges with additional PSD required.*
- Post-transplant consults and lab work through post-transplant day 100 $60,000.00
- Consolidation radiation treatments (IMRT) to the mediastinum (25 treatments) $203,330.00
    - *Number of treatments may exceed this amount and will be subject to additional charges with additional PSD required.*

Our records reflect that you do not qualify for any third party general medical insurance coverage for these services and do not meet institutional criteria for financial assistance from Mayo Clinic. ***Therefore, prior to proceeding with any future scheduling, we would require a Pre-Service Deposit in the amount of $451,330.00 in addition to payment in full of any outstanding balances at the time services are being requested.***

Please be advised that all dollars quoted are only an estimate of charges based on standard program orders. Actual charges and additional Pre-Service Deposit amounts may vary and be required based on patient's medical condition while undergoing care at Mayo Clinic Rochester.

Sincerely,

Transplant Financial Services

MAYO CLINIC

ESTIMATE

Hospital: Mayo Clinic Rochester

Mayo Clinic
200 First Street SW
Rochester, MN 55905
Business Service: 507-284-4024
Schedule an Appointment: 507-538-3270

Patient Name: Leonardo Konarzewski
Patient Address: Street Libia Rua Libia 125
Porto Alegre, MN 91370210
Service Date: 6/17/2015
Patient MRN: 09-030-806
Insurance: Self Pay

Service: Plerixafor 24mg and Injection costs. Total for 3 treatment sessions is $33,009.00

Facility Patient Amount:	$33,000.00 *
Clinic Patient Amount:	$0.00 *
Total Estimated Patient Amount:	**$33,000.00** *

** rounded*

Est ID: 204934

COMMENTS

Date: _____ **Time:** _____

Notes:

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The above estimated cost is for 3 treatments of Plerixafor 24mg doses. This estimate is NOT a guarantee of charges as individual patient response will determine the number of treatments. Additional treatments may be needed which will increase the cost to the patient.

****

ESTIMATED PATIENT FINANCIAL RESPONSIBILITY

The information provided in this worksheet is a best **ESTIMATE** based on the information we currently have and is not a guarantee of what you will be charged. Please understand that in many cases it is impossible to predict the final charges that will result, as there are variables involved in your actual services such as: the length of time spent in surgery or recovery, specific equipment, supplies and medications required, additional tests required by your physician, and/or any unusual special care or unexpected conditions or complications. If you have insurance, your benefits will ultimately determine the amount you owe (including deductibles, co-pay, co-insurance, and out-of-pocket maximums).

Patient/Guarantor Signature: _____

Prepared By: M096821 on 6/22/2015 9:27:09AM

ESTIMATE

Hospital: Mayo Clinic Rochester

Mayo Clinic
200 First Street SW
Rochester, MN 55905
Business Service: 507-284-4024
Schedule an Appointment: 507-538-3270

Patient Name: test test
Patient Address:

Service Date: 6/19/2015
Patient MRN:
Insurance: Self Pay

Service: Radiation (IMRT) Simulation and 25 Treatments

Facility Patient Amount:	$203,330.00 *
Clinic Patient Amount:	$0.00 *
Total Estimated Patient Amount:	**$203,330.00** *

* rounded

Est ID: 205701

COMMENTS

Date: _____ **Time:** _____

Notes:

The above estimated cost is for a Radiation Oncology simulation and 25 treatments of IMRT. Additional treatments maybe ordered and will have a significant increase in the total cost of treatment. Additional deposits may be requested from the patient.

ESTIMATED PATIENT FINANCIAL RESPONSIBILITY

The information provided in this worksheet is a best **ESTIMATE** based on the information we currently have and is not a guarantee of what you will be charged. Please understand that in many cases it is impossible to predict the final charges that will result, as there are variables involved in your actual services such as: the length of time spent in surgery or recovery, specific equipment, supplies and medications required, additional tests required by your physician, and/or any unusual special care or unexpected conditions or complications. If you have insurance, your benefits will ultimately determine the amount you owe (including deductibles, co-pay, co-insurance, and out-of-pocket maximums).

Patient/Guarantor Signature: _____

Prepared By: M096821 on 6/19/2015 3:29:09PM

mayo mayo

ESTIMATE

AUTOLOGOUS PERIPHERAL BLOOD STEM CELL (PBSC) TRANSPLANT
ESTIMATED CHARGES AT MAYO CLINIC ROCHESTER

The following estimate for Autologous Peripheral Blood Stem Cell Collection and Transplant at Mayo Clinic can serve as a guideline for patients and third party payers. Actual charges vary depending on the patient's medical condition both pre and post transplant.

A. Evaluation and Collection - 5 collections (average) • Conditioning Chemo • Growth Factor • Collection	$40,000 - $55,000*
B. Hospitalization for transplant - Inpatient • Physician Fees • Facility Fees	75,000 - 100,000*
C. Outpatient Follow-up Charges	30,000 - 60,000
Total **estimated** charges	$145,000 - $215,000

• Pre-Service Deposit for evaluation:	$ 55,000*
• Pre-Service Deposit prior to listing for transplant:	$160,000*

The above estimates do not include costs related to non-medical expenses (travel, food, and lodging) or medical expenses incurred while on the waiting list for a transplant.

Hospital and Mayo Clinic claims will be submitted to the patient's insurance carrier(s). Personal responsibility balances are due upon receipt of the monthly statement, unless other arrangements have been made with a Mayo Clinic Representative.

*Self-pay patients should be prepared to make the required pre-service deposit (as indicated above) prior to starting their evaluation and again before being listed for transplant.

Revised 10/2013
Mayo-Rochester