

Maryland Cancer Fund

Attachment B: SAMPLE Non-MHIP Treatment Plan and Budget Template for Paying Fee-for-Service

Name of Organization/Entity applying for Grant: _____ Dorchester County Health Department: _____

Patient Name: _____ Jane Doe _____ Date of Birth: _____ 01/01/1943 _____

Diagnosis: _____ Colorectal Cancer _____ Date of Diagnosis: _____ 02/07/2008 _____

Comments: Client screened under CRF program. Found to have Stage II colorectal cancer. Needs surgery and chemotherapy.

Treatment Plan for (date) 2/2008 to (date) 10/2008 Primary Treating Physician's Name: _____

Procedure and frequency of Treatment	Date Anticipated	CPT Codes Anticipated (if applicable)	Estimated Costs	Basis for costs (Medicaid or HSCRC-regulated rate for each procedure)
<i>CT of Abdomen</i>	<i>February, 2008</i>	<i>74170</i>	<i>\$226</i>	<i>Medical Assistance</i>
<i>Hospitalization for colon resection with reanastomosis</i>	<i>February, 2008</i>	<i>See below</i>		
<i>Surgeon</i>		<i>44140</i>	<i>\$426</i>	<i>Medical Assistance</i>
<i>Anesthesiologist</i>		<i>44140-30</i>	<i>\$142</i>	<i>Medical Assistance</i>
<i>In-patient Pharmacy</i>		<i>Various (list if known)</i>	<i>\$500</i>	<i>HSCRC if regulated; Medical Assistance otherwise</i>
<i>In-patient Laboratory, EKG, blood tests, etc.</i>		<i>Various</i>	<i>\$1,000</i>	<i>HSCRC if regulated; Medical Assistance otherwise</i>
<i>In-patient Pathology</i>		<i>88309</i>	<i>\$236</i>	<i>HSCRC if regulated; Medical Assistance otherwise</i>

Procedure and frequency of Treatment	Date Anticipated	CPT Codes Anticipated (if applicable)	Estimated Costs	Basis for costs (Medicaid or HSCRC-regulated rate for each procedure)
<i>Hospital room fee, 7 days</i>		<i>UB92</i>	<i>7 x 1500 =\$10,500</i>	<i>HSCRC</i>
<i>Operating room fees</i>		<i>44140</i>	<i>\$3250</i>	<i>HSCRC</i>
<i>Initial surgeon visit—in patient</i>		<i>99222</i>	<i>1 x \$ 24.50</i>	<i>Medical Assistance</i>
<i>Surgeon visits x 7—in patient</i>		<i>99232</i>	<i>7 x \$ 16= \$112</i>	<i>Medical Assistance</i>
<i>Surgical out patient visits x 4</i>	<i>February-April, 2008</i>	<i>99213</i>	<i>3 x 51.92=\$155.76</i>	<i>Medical Assistance</i>
<i>Oncologist out patient visits x 16</i>	<i>March-September, 2008</i>	<i>99204 99212</i>	<i>1 x 136.30=\$136.30 15 x 37.00 =\$555</i>	<i>Medical Assistance</i>
<i>Out-patient pharmacy</i>	<i>March-September, 2008</i>	<i>Various (or list if known)</i>	<i>\$5,000</i>	<i>Medical Assistance</i>
<i>Out-patient laboratory</i>			<i>\$500</i>	<i>Medical Assistance</i>
Sub Total			\$22,763.56	
Indirect (7% of \$20,000 max.) (Maximum of 7% of total for Local Health Departments, 10% for non-LHD applicants)			\$1400	
Total Requested			\$21,400	

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Attachment C: Sample Treatment Plan and Budget Template using Maryland Health Insurance Plan

Name of Organization/Entity applying for Grant: _____Somerset County Health Department_____

Patient Name: _____John Sample_____ Date of Birth: _____3/3/1930_____

Diagnosis: _____Prostate Cancer_____ Date of Diagnosis: _____1/2/2008_____

Comments: _____Diagnosed at hospital; no source of funds for treatment. Surgery recommended.

Treatment Plan for (date) __4/2008__ to (date) __6/2008__ Primary Treating Physician's Name: _____

Procedure and frequency of Treatment	Date Anticipated	CPT Codes Anticipated (if applicable)	Estimated Costs	Basis for costs (MHIP rates)
<i>Maryland Health Insurance Plan (MHIP) \$1000 PPO plan</i>	<i>April 2008— September 2008</i>	<i>N/A</i>	<i>\$370 x 6 months=\$2220</i>	<i>MHIP+ \$500, PPO Plan 3</i>
<i>MHIP Buy Down for preexisting condition</i>	<i>April 2008— September 2008</i>	<i>N/A</i>	<i>\$37 x 6 months = \$222</i>	<i>10% of premium</i>
<i>MHIP deductible and co-payments</i>	<i>April 2008— September 2008</i>	<i>N/A</i>	<i>\$3000</i>	<i>MHIP maximum out of pocket expenses</i>
Sub Total for Treatment			\$5442	
Indirect costs (Maximum of 7% of total for Local Health Departments, 10% for non-LHD applicants)			\$410	
Total Requested (Treatment + Indirect)			\$5852	