Midwest Transplant Network
Funeral Home Billing Form

Donor Name: _____

Referral #_____ Recovery Date: _____

The Midwest Transplant Network was responsible for the recovery of the following items:

[ ] Bone [ ] Skin [ ] Heart for Valves/Organs [ ] Corneas/Sclera Recovered by MTN

[ ] Eyes/Cornea Recovered by Eye Bank, will not be reimbursed by Midwest Transplant Network

Midwest Transplant Network recognizes the additional time and supplies are required to prepare a donor case and its willing to reimburse for additional fees that are considered reasonable. Additional fees are paid directly to the establishment that performs embalming/preparation. To facilitate reimbursement of additional fees, complete this form and mail to the Midwest Transplant Network. *Please make a copy for your files.*

This space is for Recovery Agency comments discussed with Funeral Home. *Attach a separated sheet if necessary* _____

_____

_____

_____

_____

_____

_____

Mail or fax this invoice to:

Midwest Transplant Network
1900 W. 47th Place, Suite 400
Westwood, KS 66205
Phone: 913.262.1668
Fax: 913.261.6411

Reimbursement subject to denial if this form is not received within 90 days post recovery.

Establishment performing preparation/reconstruction:

_____
(Enter Name of establishment performing embalming/preparation)

Address_____

City/State_____ Zip: _____

Establishment Phone: _____ Contact Person's Name: _____

Email: _____

To leave feedback on this case, please go to www.mwtn.org/survey

MIDWEST TRANSPLANT NETWORK

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Additional fees associated with reconstruction/preparation of:
(Check all applicable categories that are pertinent to the specific Recovery Agency being invoiced and insert the amount of your fee for each)

[ ] Upper & Lower Bone *(suggested fee $175.00)*……..$_____

[ ] Skin *(suggested fee $100.00)*……..…… _____

[ ] Heart for Valves/Organs *(suggested fee $75.00)*… ……_____

[ ] Corneas/Sclera *(suggested fee $25.00 if recovered by MTN)* ……..…….. _____

[ ] Mileage *(If applicable complete the section on mileage and enter the amount here)*…… _____

[ ] * Other *(Subject to approval by Recovery Agency)*……... _____

Total additional fees ……..……..$_____

**Reimbursement fees paid by the Recovery Agency are subject to Medicare and Medicaid guidelines. Please use your letterhead and/or copy of GPL to explain the reason for fees listed in the Other category or charges that exceed the suggested fees. All invoices are subject to the approval of the Recovery Agency.*

Mileage Information: ***(If Applicable)***

Transfer from: _____ to: _____

And then from: _____ to: _____

Total Miles: _____ @ $ _____per mile = Total mileage fees: _____

Signature of lead embalmer: _____ **Embalmer's License#**_____

_____
(Print Name)

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