MIDWEST TRANSPLANT
Give Hope. Share Life.®

Midwest Transplant Network
Funeral Home Billing Form

Donor name: _____

Referral number:_____ Recovery date:_____

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

☐ Bone ☐ Skin ☐ Heart for valves/organs

☐ Chest cavity was opened for sternum and pericardium recovery only; no vascular systems were compromised *(no additional reimbursement will be offered)*

Cornea/sclera/eye recovery was performed by:

☐ Midwest Transplant Network ☐ Eye bank *(will not be reimbursed by Midwest Transplant Network)*

Midwest Transplant Network staff members recognize the additional time and supplies required to prepare a donor case, and we are willing to reimburse for reasonable additional fees. We pay additional fees directly to the establishment that performs embalming/preparation. To facilitate reimbursement of additional fees, complete this form and mail to Midwest Transplant Network. *Please make a copy for your files.*

Funeral home supplies provided:

☐ Unionall

☐ Skin pack

Mail or fax this invoice to:
Midwest Transplant Network
1900 W. 47th Place, Suite 400 • Westwood, KS 66205
Phone: 913-261-6111 • Fax: 913-233-4997

Preparation/reconstitution establishment:

_____
Name of establishment performing embalming/preparation

Address: _____

City/State: _____ ZIP code: _____ Establishment phone: _____

Contact person's name: _____ Contact person's email: _____

To leave feedback on this case, please visit **mwtn.org/survey**

GP 112 (R8: 06/23)

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

Additional fees associated with reconstruction/preparation of:

(Check all applicable categories that are pertinent to Midwest Transplant Network and insert the amount of your fee for each)

☐ Bone *(suggested fee: $225.00)* ..... $ _____

☐ Skin *(suggested fee: $150.00)* ..... $ _____

☐ Heart for valves/organs *(suggested fee: $75.00)* ..... $ _____

☐ Cornea/sclera/eye *(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 the 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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