YH26-0001 Exhibit B - AHCCCS Transplant Invoice and Instructions

CONTRACTOR FACILITY NAME FACILITY ADDRESS		
CITY, STATE ZIP		
CONTRACTOR CONTACT NAME		
CONTACT INFORMATION		
	-	
SUPERVISOR CONTACT		

AHCCCS TRANSPLANT INVOICE

DO NOT SEPARATE

BILL TO: AHCCCS or Plan						
DATE BILLED	AUTHORIZATION	D/	ATES COVERED	CONTRACTOR ID		
MEMBER NAME	MEMBER ID	COM	PONENT BILLED	TOTAL BILLED		
BILLED CHARGES DETAILED						
		BER OF BILLED				
		PACKET	FORM TYPE			
INPA	TIENT		\$			
OUTP	ATIENT		\$			
PROF	FEES		\$			
EXPECTED PAYMENT \$						

PLEASE REMIT PAYMENT TO:

**Include only if different from
billing facility

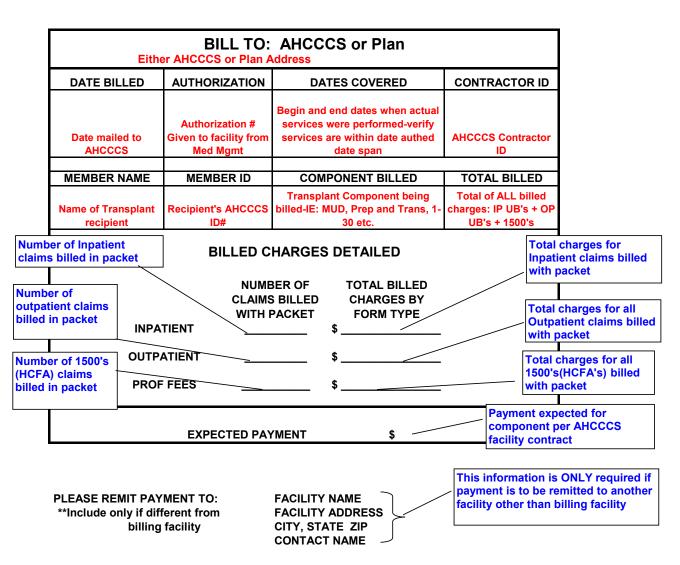
FACILITY NAME FACILITY ADDRESS CITY, STATE ZIP CONTACT NAME

All Hospital, physician, and professional billing are to be included on this invoice.

See Section 9 of the Scope of Work for submission instructions.

	HOSPITAL BILLING FACILITY
CONTRACTOR FACILITY FACILITY ADDRESS CITY, STATE ZIP	TRANSPLANT FACILITY ADDRESS
CONTRACTOR CONTACT NAME CONTACT INFORMATION	BILLING PERSON'S PHONE #, FAX# AND EMAIL ADDRESS
SUPERVISOR CONTACT	SUPERVISOR CONTACT PHONE, FAX AND EMAIL ADDRESS NEEDED IN THE EVENT THAT BILLING CONTACT CANNOT BE REACHED

TRANSPLANT INVOICE INSTRUCTIONS DO NOT SEPARATE



See Section 9 of the Scope of Work for submission instructions.