BOSTON MEDICAL CENTER

EXCEPTIONAL CARE. WITHOUT EXCEPTION.

Effective 5/1/2017

Infertility Self Pay Fee Schedule

CPT	Service	Professional	Hospital Fee	Total Fee	Notes
58558	HYSTEROSCOPY WITH BIOPSY	$463.0	$1,666.2	$2,129.2	
76831	SONOHYSTEROGRAM	$64.0	$674.4	$738.4	Radiology
58322	ARTIFICIAL INSEMINATION, INTRAUTERINE	$126.4	$252.0	$378.4	$525.6
58323	SPERM WASHING	$27.2	$120.0	$147.2	
58340	CATHETER FOR HYSTEROGRAPHY	$130.4	$244.2	$374.6	Radiology
58555	HYSTEROSCOPY, DIAGNOSTIC (SEPERATE PROC)	$411.2	$1,666.2	$2,077.4	
74740	X-RAY,FEMALE GENITAL TRACT	$43.2	$414.0	$457.2	Radiology
76830	VAGINAL SONOGRAM	$76.8	$663.0	$739.8	Radiology
99204	OFFICE/OUTPATIENT VISIT, NEW	$100.0	$300.0	$400.0	
99214	OFFICE/OUTPATIENT VISIT, EST	$65.0	$179.4	$244.4	

	Laboratory Tests	Hospital Fee	Total Fee
82670	ESTRADIOL *(infertility lab)*	$75.6	$75.6
83001	Follicle Stimulating Hormone (FSH) *(infertility lab)*	$50.4	$50.4
83520	AMH *(infertility lab)*	$34.2	$34.2
84146	Prolactin	$52.8	$52.8
81401	Spinal Muscular atrophy carrier	$1,207.8	$1,207.8
84443	Thyroid Stimulating Hormone	$45.6	$45.6
84144	Progesterone	$54.0	$54.0
86762	Rubella Antibody	$39.0	$39.0
86592	RPR	$15.0	$15.0
86803	Hepatitis C Antibody	$31.8	$31.8
86703	HIV	$60.6	$60.6
86787	Varicella IgG	$55.8	$55.8
83890	Cystic Fibrosis	$465.0	$465.0

Complete cost for Tubal Reversal (excluding lab work) $11,000 paid before surgery can be scheduled. All fees are subject to change based on diagnosis and treatment. It is patients' responsibility to know their insurance plan, deductible rules, and coverage for preconception laboratory testing.

I have received the information on the Boston Medical Center fees associated with Infertility Services

Reproductive Endocrinology & Infertility
720 Harrison Ave Suite 1105
Boston, MA 02118
617-414-2000

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Radiology Patient Payment Form

Hysterosalpinogram or Hysterosonogram
Self Pay or Non Covered Patients

PATIENT NAME _____ MRN _____ DATE _____

REFERRING PROVIDER _____ CLINIC PHONE NUMBER _____

Check the Box below to represent the services being received by this patient

CPT	Service Code	**Hysterosalpingogram** ☐	Facility Fee	Hospital Fee less 40%- Domestic
58340		Catheterization & Introduction of Saline or Contrast Media	$ 407.00	$ 244.20
74740		Hysterosalpingography, Radiological Supervision & Interpretation	$ 690.00	$ 414.00
	13640946	Contrast Media	$ 174.00	$ 104.40
132042	83520052	Supplies	$ 57.00	$ 34.20
			Total	**$ 796.80**
		Hysterosonogram ☐		
58340		Catheterization & Introduction of Saline or Contras	$ 407.00	$ 244.20
76831	83001000	Saline infusion Hysterosonogram, including color flow Doppler, when performed.	$ 1,124.00	$ 674.40
132042	83520052	Supplies	$ 57.00	$ 34.20
			Total	**$ 952.80**

**Patient is required to pay at Patient Financial Services-Cashier booth in the Newton Pavillion Bldg, 88 East Newton St. 2nd Floor, prior to receiving the services from Radiology.
These charges only include the facility fees.

For Patient Financial Services Staff Only. Collect the above amount from the patient and have the patient sign below. Provide a copy to the patient as a receipt for payment.
Amount Received from the Patient $ Date
Patient Signature
Staff Signature