

Patient Price List

at Bridgton Hospital



Inpatient Charges

DAILY ROOM RATES

Room Charges	Daily Rate
Intensive Care	\$2,968
Medical/Surgical	\$1,204
Maternity	\$1,058
Newborn Care Fee	\$621

HOSPITAL CARE

	Level	Professional Fee
Hospital New Patient Consult	Level 1	\$90.50
	Level 2	\$131.00
	Level 3	\$180.00
	Level 4	\$218.50
	Level 5	\$278.75
	Duration	Professional Fee
Initial Hospital Care/Day	30 Minutes	\$166.75
	30 Minutes	\$231.50
	40 Minutes	\$287.50
	Duration	Professional Fee
Subsequent Hospital Care/Day	20 Minutes	\$86.00
	40 Minutes	\$117.75
	55 Minutes	\$176.25

Reimbursement to the hospital (and the patient's financial responsibility) will also vary based on the term of any insurance coverage, contractual reimbursement rates, deductible, copay, and coinsurance.

The above 2016 charge estimates are based on rates as of 07/01/2016. Charges for specific patients will depend on many factors including the physician, the condition of the patient, unexpected complications, or additional procedures required. These charges are to be considered estimates only and are not a guarantee of final costs. These are hospital charges only except where indicated. Other fees and charges are not included such as surgeon or other physician fees, radiologist, and other non-facility fees.

If you have any questions please contact our billing office at 207-795-2237

Emergency Department Charges

Level	Facility Charge
ED Level 1	\$107.00
ED Level 2	\$178.25
ED Level 3	\$365.50
ED Level 4	\$667.25
ED Level 5	\$1,082.50
Critical Care - 1st Hour	\$1,783.00
Critical Care - Each Additional ½ Hour	\$445.75

Reimbursement to the hospital (and the patient's financial responsibility) will also vary based on the term of any insurance coverage, contractual reimbursement rates, deductible, copay, and coinsurance.

The above 2016 charge estimates are based on rates as of 07/01/2016. Charges for specific patients will depend on many factors including the physician, the condition of the patient, unexpected complications, or additional procedures required. These charges are to be considered estimates only and are not a guarantee of final costs. These are hospital charges only except where indicated. Other fees and charges are not included such as surgeon or other physician fees, radiologist, and other non-facility fees.

If you have any questions please contact our billing office at 207-795-2237

Top 20 MS-DRGS

MS DRG	Description	Average Charges
948	SIGNS SYMPTOMS W/O MCC	\$18,288.10
795	NORMAL NEWBORN	\$2,347.56
775	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	\$7,769.08
794	NEONATE W OTHER SIGNIFICANT PROBLEMS	\$3,817.86
947	SIGNS SYMPTOMS W MCC	\$20,053.98
189	PULMONARY EDEMA RESPIRATORY FAILURE	\$17,846.71
766	CESAREAN SECTION W/O CC/MCC	\$19,302.69
690	KIDNEY URINARY TRACT INFECTIONS W/O MCC	\$12,595.71
603	CELLULITIS W/O MCC	\$11,710.85
872	SEPTICEMIA OR SEVERE SEPSIS W/O MV >96 HOURS W/O MCC	\$21,381.41
194	SIMPLE PNEUMONIA PLEURISY W CC	\$18,694.50
871	SEPTICEMIA OR SEVERE SEPSIS W/O MV >96 HOURS W MCC	\$18,991.57
178	RESPIRATORY INFECTIONS INFLAMMATIONS W CC	\$14,613.86
176	PULMONARY EMBOLISM W/O MCC	\$18,675.04
392	ESOPHAGITIS GASTROENT MISC DIGEST DISORDERS W/O MCC	\$13,550.69
560	AFTERCARE MUSCULOSKELETAL SYSTEM CONNECTIVE TISSUE W CC	\$31,698.35
292	HEART FAILURE SHOCK W CC	\$12,587.53
293	HEART FAILURE SHOCK W/O CC/MCC	\$13,362.96
683	RENAL FAILURE W CC	\$13,871.31
066	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W/O CC/MCC	\$12,583.15

Reimbursement to the hospital (and the patient's financial responsibility) will also vary based on the term of any insurance coverage, contractual reimbursement rates, deductible, copay, and coinsurance.

The above 2016 charge estimates are based on rates as of 07/01/2016. Charges for specific patients will depend on many factors including the physician, the condition of the patient, unexpected complications, or additional procedures required. These charges are to be considered estimates only and are not a guarantee of final costs. These are hospital charges only except where indicated. Other fees and charges are not included such as surgeon or other physician fees, radiologist, and other non-facility fees.

If you have any questions please contact our billing office at 207-795-2237

Provider Based Practice Charges

NEW PATIENTS

	Level	Professional Fee	Facility Fee
Office Visits	Level 1	\$59.25	\$56.25
	Level 2	\$100.75	\$77.00
	Level 3	\$148.75	\$77.00
	Level 4	\$188.25	\$98.75
	Level 5	\$247.50	\$136.25

	Age	Professional Fee
Physicals	Age 0-1	\$197.25
	Age 1-4	\$211.00
	Age 5-11	\$207.00
	Age 12-17	\$213.50
	Age 18-39	\$209.00
	Age 40-64	\$240.00
	Age 64+	\$260.00

ESTABLISHED PATIENTS

	Level	Professional Fee	Facility Fee
Office Visits	Level 1	\$33.25	\$56.25
	Level 2	\$58.25	\$77.00
	Level 3	\$72.75	\$77.00
	Level 4	\$134.25	\$98.75
	Level 5	\$191.25	\$136.25

	Age	Professional Fee
Physicals	Age 0-1	\$160.50
	Age 1-4	\$180.50
	Age 5-11	\$180.50
	Age 12-17	\$178.25
	Age 18-39	\$177.25
	Age 40-64	\$206.00
	Age 64+	\$223.75

Reimbursement to the hospital (and the patient's financial responsibility) will also vary based on the term of any insurance coverage, contractual reimbursement rates, deductible, copay, and coinsurance.

The above 2016 charge estimates are based on rates as of 07/01/2016. Charges for specific patients will depend on many factors including the physician, the condition of the patient, unexpected complications, or additional procedures required. These charges are to be considered estimates only and are not a guarantee of final costs. These are hospital charges only except where indicated. Other fees and charges are not included such as surgeon or other physician fees, radiologist, and other non-facility fees.

If you have any questions please contact our billing office at 207-795-2237

Provider Based Practice Charges, *continued*

CONSULTS

	Level	Professional Fee
Outpatient Hospital Consult	Level 1	\$118.50
	Level 2	\$154.00
	Level 3	\$218.50
	Level 4	\$267.25
	Level 5	\$333.75
	Duration	Professional Fee
Initial Inpatient Consult	20 Minutes	\$128.50
	40 Minutes	\$170.75
	55 Minutes	\$215.50
	80 Minutes	\$277.00
	110 Minutes	\$349.25
	Duration	Professional Fee
Office Consult	30 Minutes	\$118.50
	30 Minutes	\$173.75
	40 Minutes	\$226.75
	60 Minutes	\$298.50
	80 Minutes	\$376.50

Reimbursement to the hospital (and the patient's financial responsibility) will also vary based on the term of any insurance coverage, contractual reimbursement rates, deductible, copay, and coinsurance.

The above 2016 charge estimates are based on rates as of 07/01/2016. Charges for specific patients will depend on many factors including the physician, the condition of the patient, unexpected complications, or additional procedures required. These charges are to be considered estimates only and are not a guarantee of final costs. These are hospital charges only except where indicated. Other fees and charges are not included such as surgeon or other physician fees, radiologist, and other non-facility fees.

If you have any questions please contact our billing office at 207-795-2237

Radiology Charges

CPT	Description	BH
70250	XR Skull 1-3 Views	\$229.50
70260	XR Skull Complete 4 Views	\$363.00
70450	CT Head wo Contrast	\$1,274.75
70470	CT Head w+wo Contrast	\$1,899.50
70480	CT Orbit wo Contrast	\$1,449.25
70486	CT Axial or Coronol Face wo Contrast	\$923.00
70540	MRI Orbit and or Face wo Contrast	\$1,191.50
70542	MRI Orbit and or Face w Contrast	\$1,445.50
70551	MRI Brain wo Contrast	\$1,191.50
70552	MRI Brain w Contrast	\$1,445.50
71020	XR Chest PA+Lateral	\$249.50
71101	XR Ribs Right w PA Chest	\$362.00
72040	XR Cervical Spine	\$273.00
72100	XR Lumbar Spine AP + Lateral	\$330.25
72141	MRI Cervical Spine wo Contrast	\$1,191.50
72192	CT Pelvis wo Contrast	\$1,363.25
72193	CT Pelvis w Contrast	\$1,485.75
72194	CT Pelvis w+wo Contrast	\$2,044.00
73706	CT Angio Low Ext Bilat w+wo Contrast	\$2,572.75
	CT Angio Lower Ext LT w+wo Contrast	\$1,287.00

Reimbursement to the hospital (and the patient's financial responsibility) will also vary based on the term of any insurance coverage, contractual reimbursement rates, deductible, copay, and coinsurance.

The above 2016 charge estimates are based on rates as of 07/01/2016. Charges for specific patients will depend on many factors including the physician, the condition of the patient, unexpected complications, or additional procedures required. These charges are to be considered estimates only and are not a guarantee of final costs. These are hospital charges only except where indicated. Other fees and charges are not included such as surgeon or other physician fees, radiologist, and other non-facility fees.

If you have any questions please contact our billing office at 207-795-2237

Radiology Charges, *continued*

CPT	Description	BH
	CT Angio Lower Ext RT w+wo Contrast	\$1,287.00
73718	MRI lower extremity w/o dye	\$1,191.50
73721	MRI Knee Left wo Contrast	\$1,191.50
73722	MRI Knee Left w Contrast	\$1,445.50
73723	MRI Knee Left w+wo Contrast	\$1,824.50
74240	XR UGI Series wo KUB	\$601.75
76706	US AAA Screening	\$393.00
76642	US Breasts Limited	\$291.75
76770	US Retroperitoneal Complete	\$565.25
76881	US Left Ext Comp	\$319.00
76881	US Right Ext Comp	\$319.00
76882	US Left Ext Ltd	\$206.75
76882	US Right Ext Ltd	\$206.75
77073	CT Bone Length Study	\$430.25
78803	NM Tumor Imaging SPECT	\$979.25
78804	NM Tumor Imaging WB Multi	\$1685.25
93017	Cardiovascular Stress Test Tracing	\$571.75

Reimbursement to the hospital (and the patient's financial responsibility) will also vary based on the term of any insurance coverage, contractual reimbursement rates, deductible, copay, and coinsurance.

The above 2016 charge estimates are based on rates as of 07/01/2016. Charges for specific patients will depend on many factors including the physician, the condition of the patient, unexpected complications, or additional procedures required. These charges are to be considered estimates only and are not a guarantee of final costs. These are hospital charges only except where indicated. Other fees and charges are not included such as surgeon or other physician fees, radiologist, and other non-facility fees.

If you have any questions please contact our billing office at 207-795-2237

Lab Charges

CPT	Description	BH
80048	\$ Basic Metabolic 80048	\$132.75
80061	Coronary Risk Panel	\$120.75
80156	Carbamazepine Level	\$135.75
81002	Urine Test	\$35.00
81003	Urns Dip Stick	\$41.75
81025	Pregnancy Test	\$49.00
82270	Hemocult	\$32.50
82274	Occult Blood FIT, Stool	\$60.50
82803	Mixed Blood Gas	\$251.50
82947	Glucose Test	\$43.00
83001	Follicle Stimulating Hormone	\$155.50
83516	Anti Mullerian Hormone	\$284.00
83520	GM1 Antibody Panel	\$116.00
84144	Progesterone Level	\$164.50
84403	Testosterone Level	\$180.00
84520	Blood Urea Nitrogen	\$39.50
86706	Hepatitis B surface Antibody	\$66.00
86762	Rubella IgG Ab	\$51.25
86765	Rubeola IgG Ab	\$29.00
86787	Varicella IgG Ab	\$71.75
87088	Urine Culture	\$77.75
87491	Chlamydia	\$47.50
87535	HIV	\$414.00
87591	Gonorrhea	\$63.00
87624	HPV High Risk Screen by TMA	\$93.50
87880	Strep Test	\$58.00
88341	Immunio Stain 2+	\$252.50

Reimbursement to the hospital (and the patient's financial responsibility) will also vary based on the term of any insurance coverage, contractual reimbursement rates, deductible, copay, and coinsurance.

The above 2016 charge estimates are based on rates as of 07/01/2016. Charges for specific patients will depend on many factors including the physician, the condition of the patient, unexpected complications, or additional procedures required. These charges are to be considered estimates only and are not a guarantee of final costs. These are hospital charges only except where indicated. Other fees and charges are not included such as surgeon or other physician fees, radiologist, and other non-facility fees.

If you have any questions please contact our billing office at 207-795-2237

Glossary

AMI	Acute Myocardial Infarction
Bilat	Bilateral
BX	Biopsy
CC	Complications and Comorbidities
CV	Central Venous
DRG	Diagnosis Related Group
ED	Emergency Department
EGD	Upper Endoscopy
ENDOS	Endoscopy
ESWL	Extracorporeal Shock Wave Lithotripsy
EXCIS	Excision
FB	Foreign Body
FB/DEVCE SK	Foreign Body/Device Skin
GU	Genitourinary System
I&D	Incision and drainage
IN	Insertion
LAP ASST	Laparoscopy Assisted
MCC	Major Complications and Comorbidities
MV	Mechanical Ventilation
NEC	Not Elsewhere Classified
NICU	Neonatal Intensive Care Unit
OCC	Occlusion
PERC	Pulmonary Emboli Rule out Criteria
SubQ	Subcutaneous
VAS ACC	Vascular Access

Reimbursement to the hospital (and the patient's financial responsibility) will also vary based on the term of any insurance coverage, contractual reimbursement rates, deductible, copay, and coinsurance.

The above 2016 charge estimates are based on rates as of 07/01/2016. Charges for specific patients will depend on many factors including the physician, the condition of the patient, unexpected complications, or additional procedures required. These charges are to be considered estimates only and are not a guarantee of final costs. These are hospital charges only except where indicated. Other fees and charges are not included such as surgeon or other physician fees, radiologist, and other non-facility fees.

If you have any questions please contact our billing office at 207-795-2237