

**APPENDIX B - BRONX
 BID AMOUNT PER SERVICE - COST PROPOSAL SUBMITTAL FORM
 MANDATORY SERVICES**

A. EXAMINATIONS

| CODE | DESCRIPTION | ANNUAL VOLUME | YEAR 1 | | YEAR 2 | | YEAR 3 | | 3 YEAR TOTAL |
|-------------------------------|---|------------------|-----------|-------|-----------|-------|-----------|-------|-----------------|
| | | | UNIT COST | TOTAL | UNIT COST | TOTAL | UNIT COST | TOTAL | |
| 90001 | Complete Specialist Exam | 10,750 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 90002 | Complete Orthopedic Exam | 1,065 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 90003 | Complete Psychiatric Exam | 10,255 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 90004 | Complete Neurological Exam | 175 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 90009 | Complete Pediatric Exam | 1,285 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 90008 | Drug/Alcohol Addiction Exam* | 1 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 92506 | Speech-Language Evaluation | 285 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| PSYCHOLOGICAL DIAGNOSTIC TEST | | | | | | | | | |
| 9800 | Intelligence Evaluation (see form DDD-4130) | 740 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 9804 | Non-Verbal Intelligence Evaluation (see form DDD-4130) | 150 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |

B-1

*THE UNIT COST FOR THE DRUG/ALCOHOL EXAM (90008) SHOULD NOT INCLUDE THE COST OF THE 90003 EXAM. THE ANNUAL VOLUME FOR THE PSYCHIATRIC EXAM INCLUDES ANY PSYCHIATRIC REFERRALS AS A RESULT OF THE DRUG/ALCOHOL EXAM (90008).

**RATES MUST NOT EXCEED DDD FEE SCHEDULE FOR THE TERM OF THE CONTRACT.
 DDD'S FEE SCHEDULE IS INCLUDED IN APPENDIX N.**

**APPENDIX B COST PROPOSAL FORM - BRONX
PAGE 2**

| CODE | DESCRIPTION | ANNUAL VOLUME | YEAR 1 | | YEAR 2 | | YEAR 3 | | 3 YEAR TOTAL |
|-----------------------|--|------------------|-----------|-------|-----------|-------|-----------|-------|-----------------|
| | | | UNIT COST | TOTAL | UNIT COST | TOTAL | UNIT COST | TOTAL | |
| RESPIRATORY SYSTEM | | | | | | | | | |
| 94010 | Ventilation Tests | 115 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 94060 | Ventilation Tests before and after bronchodilators | 75 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| CARDIOVASCULAR SYSTEM | | | | | | | | | |
| 93000 | Electrocardiogram, resting | 5 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 93015 | Treadmill exercise electrocardiography | 1 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 93910 | Doppler ultrasound Flow Meter test Bilateral, arterial only | 1 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 93911 | Doppler Ultrasound Flow Meter test after exercise, arterial only | 1 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 9390 | Toe Doppler | 1 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |

B-2

**RATES MUST NOT EXCEED DDD FEE SCHEDULE FOR THE TERM OF THE CONTRACT.
DDD'S FEE SCHEDULE IS INCLUDED IN APPENDIX N.**

**APPENDIX B - COST PROPOSAL FORM - BRONX
PAGE 3**

B. RADIOLOGY*

| CODE | DESCRIPTION | ANNUAL VOLUME | YEAR 1 | | YEAR 2 | | YEAR 3 | | 3 YEAR TOTAL |
|-------------------|---|---------------|-----------|-------|-----------|-------|-----------|-------|--------------|
| | | | UNIT COST | TOTAL | UNIT COST | TOTAL | UNIT COST | TOTAL | |
| CHEST | | | | | | | | | |
| 71010 | X-ray, chest, single PA | 1 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| SPINE AND PELVIS | | | | | | | | | |
| 72040 | X-ray spine, cervical, AP and lateral | 165 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 72070 | X-ray spine thoracic, AP and lateral | 25 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 72100 | X-ray spine lumbar, sacral AP and lateral | 1,915 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 72190 | X-ray pelvis, including hips | 15 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| UPPER EXTREMITIES | | | | | | | | | |
| 73000 | X-ray clavicle, complete | 1 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 73030 | X-ray Shoulder Complete | 165 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 73060 | X-ray humerus proximal inc shoulder | 5 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 73061 | X-ray humerus distal inc elbow | 1 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 73090 | X-ray forearm proximal inc elbow | 10 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 73091 | X-ray foreman distal inc wrist | 30 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |

B-3

* EACH X-RAY SHOULD BE PRICED AS AN INDIVIDUAL UNIT COST. DDD WILL NOT IMPLEMENT A PRICE REDUCTION METHODOLOGY BASED ON MULTIPLE OR CONTIGUOUS X-RAYS.

**RATES MUST NOT EXCEED DDD FEE SCHEDULE FOR THE TERM OF THE CONTRACT.
DDD'S FEE SCHEDULE IS INCLUDED IN APPENDIX N.**

**APPENDIX B - COST PROPOSAL FORM - BRONX
PAGE 4**

| CODE | DESCRIPTION | ANNUAL VOLUME | YEAR 1 | | YEAR 2 | | YEAR 3 | | 3 YEAR TOTAL |
|---------------------------|------------------------------|------------------|-----------|-------|-----------|-------|-----------|-------|-----------------|
| | | | UNIT COST | TOTAL | UNIT COST | TOTAL | UNIT COST | TOTAL | |
| UPPER EXTREMITIES (Cont.) | | | | | | | | | |
| 73120 | X-ray hand including fingers | 85 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| LOWER EXTREMITIES | | | | | | | | | |
| 73510 | X-ray hip joint | 85 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 73550 | X-ray femur proximal | 1 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 73551 | X-ray femur distal | 1 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 73560 | X-ray knee | 740 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 73590 | X-ray leg proximal | 10 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 73591 | X-ray leg distal | 20 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 73600 | X-ray ankle | 90 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 73620 | X-ray foot including toes | 60 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |

B-4

| | YEAR 1 | YEAR 2 | YEAR 3 | 3 YEAR TOTAL |
|------------------------------------|--------|--------|--------|-----------------|
| TOTAL FOR ALL MANDATORY PROCEDURES | _____ | _____ | _____ | _____ |

**RATES MUST NOT EXCEED DDD FEE SCHEDULE FOR THE TERM OF THE CONTRACT.
DDD'S FEE SCHEDULE IS INCLUDED IN APPENDIX N.**

**APPENDIX B - COST PROPOSAL FORM - BRONX
PAGE 5**

MANDATED CASE CONSULT SERVICES:

YEAR 1

YEAR 2

YEAR 3

INTERNAL MEDICINE

HOURLY RATE

PSYCHIATRY

HOURLY RATE

PEDIATRICS

HOURLY RATE

PSYCHOLOGY

HOURLY RATE

SPEECH AND LANGUAGE

HOURLY RATE

B-5

I, _____, representing _____
Print Name
Firm Name

am authorized to bind this offer and assure that the offer will remain open and not subject to change for a minimum of 180 days.

 Authorized Binding Signature

