

**APPENDIX B - NASSAU
 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 | 2,135 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 90002 | Complete Orthopedic Exam | 780 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 90003 | Complete Psychiatric Exam | 2,020 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 90004 | Complete Neurological Exam | 130 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 90009 | Complete Pediatric Exam | 55 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 90008 | Drug/Alcohol Addiction Exam* | 1 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 92506 | Speech-Language Evaluation | 15 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| PSYCHOLOGICAL DIAGNOSTIC TEST | | | | | | | | | |
| 9800 | Intelligence Evaluation (see form DDD-4130) | 65 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 9804 | Non-Verbal Intelligence Evaluation (see form DDD-4130) | 20 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |

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*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).

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 DDD'S FEE SCHEDULE IS INCLUDED IN APPENDIX N.**

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| 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 | 135 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 94060 | Ventilation Tests before and after bronchodilators | 60 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| CARDIOVASCULAR SYSTEM | | | | | | | | | |
| 93000 | Electrocardiogram, resting | 1 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 93015 | Treadmill exercise electrocardiography | 5 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 93910 | Doppler ultrasound Flow Meter test Bilateral, arterial only | 5 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 93911 | Doppler Ultrasound Flow Meter test after exercise, arterial only | 1 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 9390 | Toe Doppler | 1 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |

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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 | 120 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 72070 | X-ray spine thoracic, AP and lateral | 5 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 72100 | X-ray spine lumbar, sacral AP and lateral | 575 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 72190 | X-ray pelvis, including hips | 5 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| UPPER EXTREMITIES | | | | | | | | | |
| 73000 | X-ray clavicle, complete | 1 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 73030 | X-ray Shoulder Complete | 115 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 73060 | X-ray humerus proximal inc shoulder | 1 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 73061 | X-ray humerus distal inc elbow | 1 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 73090 | X-ray forearm proximal inc elbow | 5 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 73091 | X-ray foreman distal inc wrist | 10 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |

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* 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.

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| 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 | 60 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| LOWER EXTREMITIES | | | | | | | | | |
| 73510 | X-ray hip joint | 50 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 73550 | X-ray femur proximal | 1 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 73551 | X-ray femur distal | 1 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 73560 | X-ray knee | 255 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 73590 | X-ray leg proximal | 1 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 73591 | X-ray leg distal | 10 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 73600 | X-ray ankle | 45 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 73620 | X-ray foot including toes | 20 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |

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

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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

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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

