



Patient First Name: Maksim
 Patient Last Name: Rubtsov
 Record Number: Z- 6899335
 Passport Number/Nationality: 670080877

Date of Issue: 05.04.2026
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RE: Estimated Cost of Post Bone Marrow Transplantation Package

We are looking forward to welcoming you to our medical center.
 In response to your request, please find below the estimated pricing.
 This price estimate is provided based on the medical documents made available by the patient.

A. Procedure: Post Bone Marrow Transplantation Package

B. Details*

Service code	Service name	Doctor's Name	Q-ty	Cost in USD
149727	Additional three months post- transplant treatment hospitalization package		1	51,950
999343	Lodging/Accommodations** (for patient and accompanying person)		3	3,150
Total charges				55,100

**Including up to 30 days of hospitalization.
 Medication limit up to 5,500 USD**

*Quoted prices are valid for 90 days
 ** Accommodations beyond 3 months will be charged at 1050 USD per month.

The cost of the transplant includes:

1. Hospitalization, blood products,
2. Day Care , medications

The cost of the transplant excludes:

1. Package fee does not include dental treatment.
2. Package fee does not include **WHOLE EXOME SEQUENCING.**
3. Plasmapheresis treatment.

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Please note:

- Additional hospitalization days will be charged at the rate of \$ 2,500 per day.
- Any days requiring hospitalization in ICU (intensive care unit) will be charged in addition to the charge of the hospitalization day above at the rate of \$ 5400 per day.
- In the event that additional three months hospitalization package is required (beyond 6 months), it will be charged at the rate of **\$ 55,100**, will be limited up to **30 days of hospitalization**, and medication will be limited up to **\$ 5,500**. Does not include treatments of plasmapheresis.
- Any additional surgery, other than the transplant, will be charged per service.
- This quote may be changed based on the treatment instructions of the treating physicians.
- Additional costs may be incurred for additional testing and/or procedures that may arise throughout the anticipated medical care. They will be charged based on Hadassah's rate at the time of treatment.

C. Payment:

Full payment of **55,100.00 USD** is required prior to the initial assessment.

For your convenience, a bank transfer can be made to the Hadassah Medical Organization account. (Please keep in mind that it takes approximately 3 working days to credit the hospital's account).

Payment should be made payable to:

Hadassah Medical organization- swift code POALITXXX,

Bank Hapoalim, #436, Harokmim St. 26, Holon, Israel.

IBAN CODE: IL41012436000000025000

Account Number 25000

Please send a copy of your bank transfer (swift) to: [International @hadassah.org.il](mailto:International@hadassah.org.il)



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Hadassah Medical Organization (PBC)

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