

30.07.2015

To: To Whom It May Concern
Re: Rudakov Semen -880076077 Diagnosis: ALL

Assessment:

Including ambulatory Tests: Bone Scan, Pulmonary Function, M.U.G.A., Laboratory Tests, Bone Marrow Biopsy, Imaging, CT Scan and Ultra Sound, Nuclear Med., etc. \$10,500-16,000

Chemotherapy treatment: BFM Protocol (optional)

Each cycle Up to 4 days of hospitalization	\$12,600	
Not including Pharmacy services	\$1,500-2,000	
Expected 5 cycle		\$32,000-36,000
Related Medical Services: Laboratory tests, consultations		
Follow up, blood products (if needed) etc,		\$6,000-10,000
Extra days of hospitalizations (neutropenia)		\$17,500-35,000

PLEASE NOTE:

1. Not including Pharmacy services.
2. Not including cost for B.M.T. if needed a separate estimation of cost will be provided.
3. Any additional days of hospitalization will be charged at the rate of \$1,750 per day. Hospitalization in the ICU will be charged at \$4,400 per day for the first four days and \$3,150 per day from the fifth day.

4. The treating physicians may determine that other diagnostic tests other than those listed here are necessary (such as US, CT, MRI, Special Lab Tests ,etc); the costs of which are not included in this estimate will be charged under Tariff of Israeli M.O.H for tourist.

Total expected cost \$100,000 - 150,000

A deposit of **\$50,000** is required before initiating with the assessment.

May we draw your attention to the fact that the total amounts stated above are only an estimate, the actual medical and hospital costs might vary from the amount stated in this cost estimate depending on the real time medical treatment provided, including those arising from unexpected complications.

Account Details:

Medical Research and Development Fund Sheba Medical Center:

e-mail: Med-tour@sheba.health.gov.il

Account No. 508637/88 Bank Leumi Le Israel, Branch 800

19 Herzl Street, Tel Aviv, Israel

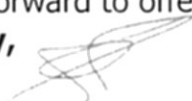
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Please feel free to contact us if you need further information.

We look forward to offering our assistance.

Sincerely,



Medical Tourism Department
Sheba Medical Center

Please confirm your receipt of, and acceptance of, the estimated cost proposal by signing the form below and returning it to our office.

TO: Medical Research Fund of Sheba Medical Center

From: _____ on behalf of _____
 Name Company / or Individual

We agree to the terms stated in your proposal and agree to pay for all medical and other services provided by the Sheba Medical Center.

Name: Miriam Pysarova

Signature: [Signature] Date: 30.07.2015

Please return by fax to (972) 3 – 530-2155