SHEBA GLOBAL
Tel HaShomer Patient Services

Tel: +972-3530-3100
Fax: +972-3530-8040

11/10/2022

To whom it may concern

Patient Name: **Milana Samigullayeva**

Diagnosis: **Ewing's sarcoma**

This cost estimate is provided based on the medical documents made available by the patient.

Assessment:

Including ambulatory Tests: Pediatric hemato-oncologist consultation, Bone Scan, Review and implementation of discs, revision of biopsy, Lab. tests + urine tests, CT, x-ray chest, US, etc. about $5,000-10,000

Possible oncological treatment (surgery, chemotherapy, radiotherapy): about $150,000-200,000

The provided cost of the assessment is an estimate and it is subject to change based on the medical recommendations.

After the assessment at Sheba Medical Center, you will be provided with an updated cost estimate for the treatment proposed by the attending physician, who will also explain the risks and benefits associated with this treatment.

The description and cost of the medical services, shall be based on the price list as published in the Ministry Of Health website http://www.health.gov.il.

Deposit of $50,000 is required before arrival at SMC for assessment and beginning of the treatment.

Account Details: Medical Research and Development Fund Sheba Medical Center:
Account No. 508637/88 Bank Leumi Le Israel, Branch 800
19 Herzl Street, Tel Aviv, Israel
Swift #LUMIILITXXX
IBAN CODE#IL290108000000050863788

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Hospitalization days will be charged at a rate of $1,500 per day and any days of and any days of hospitalization in the ICU will be charged at $3,500 per day during 4 first days, and $3,150 from 5th day.

Price quoted does not include accommodation.
A medical coordinator will accompany you at Sheba Medical Center free of charge.

Quoted prices are valid for up to two months.
Service at Sheba Medical Center is provided in English or Russian only.

We look forward to offering our assistance.

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

Global Patient Services
Sheba Medical Center, Israel
Phone: +9723-5303100

GOVERNMENT HOSPITAL SHEBA TEL-HASHOMER ISRAEL

Please confirm your receipt and acceptance of the above cost estimate 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 / Individual

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

I hereby declare that I am not a citizen of the State of Israel.

Name _____

Signature: _____ Date: _____