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

12/02/2023

To whom it may concern

Patient Name: Uskova Yesseniya -880105747

Treatment recommended:

KEYTRUDA 100 MG/4 ML **for 2 treatments**	about $16,812
15 Doctor consultation +blood tests	about $4,500
PETCT	$2,100
Possible hospitalization	about $20,000
Total:	**$43,412**

Not including special medication if needed

Not including special pharmacy services (if needed), related medical services: imaging, laboratory tests,

Consultation, follow up, Blood products (if needed) etc.

PLEASE NOTE:

1. Radiotherapy treatment if needed, will be given as a supplement estimation of cost After the simulation

2-Not including Blood products and Pharmacy services that are not included in the routine treatment.

Not including operation

The description and cost of medical services will be based on the price list published on the Ministry of Health website at: http://www.health.gov.il.

A medical coordinator will accompany you at Sheba Medical Center free of charge.

Price quoted does not include accommodation.
Hospitalization days will be charged at a rate of $1,500 per day 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

Payment

A deposit is required before scheduling the operation
And the arrival at S.M.C.
Payment can be made by means of a bank transfer to our account,

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The details of which are given below.

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

International Medical Tourism Division
Sheba Medical Center, 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.

Name: ______________________

Signature: ______________________ **Date:** ______________________

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