Transplant Request Form

Instructions: Please fill out completely and legibly before faxing the form to the number listed below. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support this request. Information contained in this form is Protected Health Information under HIPAA.

Please note: Not all services require prior authorization. You may contact customer service to determine what services require prior authorization. If the service does not require prior authorization, the service may be considered cosmetic, investigational, or may not be a covered benefit. Failure to obtain any necessary authorizations may result in denial or reduction in benefits.

Contact information (for the person completing this form)

Contact name	**Direct phone & Ext**	**Email**

Member/Patient information

First name	**Middle initial**	**Last name**

Member ID number (including prefix)	**Member date of birth** (mm/dd/yyyy)	**Phone**

Member address	**City**	**State**	**ZIP**

Service/Procedure/Treatment/Donor information

Please indicate specifics about place and type of service.

Request type

If this is related to an existing authorization, please provide the authorization number: _____

☐ Prior Authorization ☐ Organizational Determination

Treatment type (check applicable boxes)

☐ Transplant ☐ Transplant Evaluation ☐ Precertification

Place of service

☐ Blue Distinction Center ☐ CMS Transplant

☐ Other Transplant Facility _____

Primary transplant type

☐ Solid Organ
☐ Stem Cell
☐ CART

Secondary transplant type

☐ Autologous
☐ Allogenic
☐ "Mini" Allogenic
☐ N/A

Tertiary transplant type

☐ Tandem #1
☐ Tandem #2
☐ Sequential 1
☐ Sequential 2
☐ Sequential 3
☐ Sequential 4
☐ N/A

Cell Source Type

☐ Bone Marrow
☐ Peripheral Blood Stem Cell
☐ Cord Blood Single Unit
☐ Cord Blood Multiple Unit
☐ N/A

Donor type
- ☐ Related
- ☐ Unrelated

Match type
- ☐ Matched
- ☐ Mismatched

Donor class
- ☐ Cadaveric
- ☐ Living Donor
- ☐ Other

Transplant class
- ☐ Initial
- ☐ Re-Transplant
- ☐ N/A

Organ
- ☐ Liver
- ☐ Liver/Kidney
- ☐ Kidney
- ☐ Kidney/Pancreas
- ☐ Pancreas
- ☐ Heart
- ☐ Lung
  - ☐ Single ☐ Bilateral
- ☐ Heart/Lung
- ☐ Small Intestine
- ☐ Heart/Kidney
- ☐ Multi-Visceral
- ☐ N/A

Requestor & Provider details

Requestor: ☐ Member ☐ Authorized Representative ☐ Provider ☐ Facility

Name	Phone	Email

Requesting provider

Provider name	Tax ID #	NPI #	Specialty

Group/Facility name	Phone	Preferred Fax

Group/Facility address	City	State	ZIP

Contact name	Email	DRG Facility?
		☐ Yes ☐ No

Servicing provider

Provider name	Tax ID #	NPI #	Specialty

Group/Facility name	Phone	Preferred Fax

Group/Facility address	City	State	ZIP

Contact name	Email	DRG Facility?
		☐ Yes ☐ No

Procedure codes

HCPCS/CPT/CDT code	Code description	Medical reason	Start date	End date	Frequency requested

Include/attach clinical and office notes, laboratory information, imaging reports, and any other necessary information to support medical necessity. If this is a request for out-of-network services, please provide an explanation.

Please return this form and supporting documentation by fax to:
Transplant Fax: 501-301-1983