

TRANSPLANT SERVICES PRIOR AUTHORIZATION FORM

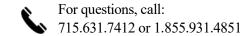
FYI: Incomplete, illegible, or inaccurate forms will be returned to the sender. Please complete the entire form and submit documentation to support medical necessity along with this request. Failure to provide required documentation may result in denial of the request.

Prior Authorization Guidelines:

- 1. Prior Authorization is required for transplant consult/ evaluation.
- 2. Prior Authorization is required for transplant listing.
- 3. Notification is required at time of transplant procedure.



Fax form and relevant clinical documentation to: 715.787.7316



PRIOR AUTHORIZATION:				
Consult/ Evaluation Date:				
Listing Date:				
Transplant Procedure Date:				
Is the member currently inpatient at the transplant facility?				
PATIENT INFORMATION:				
Name:				
Member ID:	PMI:			
Address:				
City:	State:	Zip Code:		
Date of Birth:	Phone:			
ORDERING PRACTITIONER INFORMATION:				
Practitioner Name:	Clinic NPI:			
Specialty:				
Clinic Name:				
Clinic Address:				
City:	State:	Zip Code:		
Phone:	Fax:			
TRANSPLANT PRACTITIONER INFORMATION:				
check box if same as <i>Ordering Practitioner Information</i> above*				
Practitioner Name:	Clinic NPI:			
Specialty:				
Clinic Name:				
Clinic Address:				
City:	State:	Zip Code:		
Phone:	Fax:			

FACILITY INFORMATION:	CONTRACT	ΓED NON-C	CONTRACTED
Facility Name:		Facility NPI Number:	
Facility Address:			
City:	Stat	te:	Zip Code:
Phone:	Fax	•	
TRANSPLANT COORDINATOR CON	TACT INFOR	RMATION:	
Name:			
Phone:			
Email:			
Fax Number:			
TYPE OF TRANSPLANT AND PROCE		ES:	
Please specify type of organ transplant (example: single or bilateral lung transplant)		CPT Code(s):	Procedure Date:
		CIT Couc(s).	Troccuure Date.
☐ Heart:			
☐ Lung:			
☐ Liver:			
□ Pancreas:			
☐ Small Bowel:			
☐ Small Bowel/Liver:			
☐ Multivisceral:			
☐ Hematopoietic Stem Cell:			
□ Auto □ Allo-unrelated			
☐ Umbilical cord blood			
☐ Allo-related			
☐ Allo-unspecified			
☐ Other (please specify):			
- · · ·			
ICD-10 Diagnosis Codes			
ICD-10 Codes:			
Description of Request:			