Reset Form

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. Prior Authorization is required prior to transplant procedure.

Fax form and relevant clinical documentation to: 715.787.7316

For questions, call: 715.631.7412 or 1.855.931.4851

PRIOR AUTHORIZATION:			
☐ Consult/ Evaluation	Date:		
☐ Listing	Date:		
☐ Transplant Procedure	Date:		
Is the member currently inpatient at the transplant facility?		☐ Yes	☐ No

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 ***Ordering Practitioner Information*** above*		
Practitioner Name:	Clinic NPI:	
Specialty:		
Clinic Name:		
Clinic Address:		
City:	State:	Zip Code:
Phone:	Fax:	

FACILITY INFORMATION: ☐ CONTRACTED ☐ NON-CONTRACTED		
Facility Name:		Facility NPI Number:
Facility Address:		
City:	State:	Zip Code:
Phone:	Fax:	

TRANSPLANT COORDINATOR CONTACT INFORMATION:
Name:
Phone:
Email:
Fax Number:

TYPE OF TRANSPLANT AND PROCEDURE CODES:		
Please specify type of organ transplant (example: single or bilateral lung transplant)	**CPT Code(s):**	**Procedure 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: