



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



For questions, call:
715.631.7412 or 1.855.931.4851

PRIOR AUTHORIZATION:

<input type="checkbox"/> Consult/ Evaluation	Date:
<input type="checkbox"/> Listing	Date:
<input type="checkbox"/> Transplant Procedure	Date:
Is the member currently inpatient at the transplant facility?	
<input type="checkbox"/> Yes	<input type="checkbox"/> 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:

<input type="checkbox"/> 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:			<input type="checkbox"/> CONTRACTED	<input type="checkbox"/> 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:
<input type="checkbox"/> Heart:		
<input type="checkbox"/> Lung:		
<input type="checkbox"/> Liver:		
<input type="checkbox"/> Pancreas:		
<input type="checkbox"/> Small Bowel:		
<input type="checkbox"/> Small Bowel/Liver:		
<input type="checkbox"/> Multivisceral:		
<input type="checkbox"/> Hematopoietic Stem Cell: <ul style="list-style-type: none"> <input type="checkbox"/> Auto <input type="checkbox"/> Allo-unrelated <input type="checkbox"/> Umbilical cord blood <input type="checkbox"/> Allo-related <input type="checkbox"/> Allo-unspecified 		
<input type="checkbox"/> Other (please specify):		

ICD-10 Diagnosis Codes
ICD-10 Codes:
Description of Request: