



## TRANSPLANT SERVICES NOTIFICATION FORM

**Notification Guidelines:**

1. Notification is required for transplant consult/evaluation.
2. Notification is required for transplant listing.
3. Notification is required within 24 hours of inpatient hospital admission.



Fax form and relevant clinical documentation to: 715-787-7316



For questions, call: 715-631-7412 or 1-855-931-4851

TYPE OF NOTIFICATION:	
Consult/ Evaluation	
Has the member had a consultation?	
Yes, date of consultation:	No, schedule date:
Listing	
Has the member been listed?	
Yes, date of listing:	No
Inpatient Admission	
Date of Admission:	
Is the member currently inpatient at the transplant facility?	Yes      No

TYPE OF TRANSPLANT AND ICD-10 DIAGNOSIS CODES:	
<i>Please specify type of organ transplant (for example: single or bilateral lung transplant )</i>	<i>ICD-10 Diagnosis Codes:</i>
Heart:	
Lung:	
Liver:	
Pancreas:	
Cornea:	
Trachea:	
Kidney:	
Skin:	
Bone Marrow:	
Other (please specify):	

PATIENT INFORMATION:		
Name:		
Member ID:	PMI:	
Address:		
City:	State:	Zip Code:
Date of Birth:	Phone:	

**ORDERING PRACTITIONER INFORMATION:**

Practitioner Name:		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:		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: