





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:
612-884-2499 or 1-866-610-7215

 For questions, call:
612-676-3300 or 1-888-531-1493

 E-Mail: HCM_Fax@ucare.org

 UCare's Secure E-mail Site

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:

<input type="checkbox"/> check box if same as <i>Ordering Practitioner Information</i> 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: