Clear Form

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:	
Please specify type of organ transplant (for example: single or bilateral lung transplant)	*ICD-10 Diagnosis Codes:*
☐ 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: