

**TRANSPLANT
PRIOR AUTHORIZATION REQUEST
FORM**

Please Fax with Supporting Medical Documentation to:
800-882-6147

Requests for prior authorization must be accompanied by clinical documentation that supports the need for the type of transplant being requested.

REQUIRED DOCUMENTATION:

- LETTER OF MEDICAL NECESSITY FROM THE TREATING PHYSICIAN DESCRIBING THE NEED FOR THE TRANSPLANT BEING REQUESTED.
- INITIAL AND RECENT CLINICAL EVALUATION (I.E., DIAGNOSTIC STUDIES AND LABORATORY TEST)
- A COPY OF THE TREATMENT PROTOCOL

Please note that the approval of a transplant evaluation does not guarantee the approval of a transplant.

DATE of REQUEST: _____ CLAIMANT FILE NUMBER: _____

CLAIMANT: _____ CLAIMANT DATE OF BIRTH: _____

CLAIMANT PHONE: _____

AUTHORIZED REPRESENTATIVE: _____

AUTHORIZED REPRESENTATIVE PHONE: _____

TRANSPLANT SURGEON: _____

CONDUENT PROVIDER NUMBER: _____ TAX ID: _____

REFERRING PHYSICIAN: _____

REFERRING PHYSICIAN ADDRESS: _____

PRIMARY DIAGNOSIS DESCRIPTION: _____ ICD-9 CODES (if dates of service are on or before 9/30/2015): _____

TYPE OF TRANSPLANT: _____ ICD-10 CODES (if dates of service are on or after 10/1/2015): _____

EXPECTED PROCEDURE DATE: _____ PROCEDURE CODE: _____

TRANSPLANT FACILITY: _____

TRANSPLANT FACILITY ADDRESS: _____

PHONE: _____

TRANSPLANT COORDINATOR: _____

TRANSPLANT COORDINATOR PHONE: _____