Prior Authorization

Please fax to (952) 853-8713   For questions, call (888) 467-0774

Transplant Consult and Listing

Member	
Member name:	Member ID #:
DOB:	
Requestor	
Form completed by:	Clinic/Facility:
Fax # for reply:	Phone #:
Transplant Physician	
Physician:(last name)	(first name)
Tax ID #:	Phone #:
Fax #:	
Transplant facility	
Name:	Tax ID #:
City:	State:
Fax #:	Phone #:
Please check which applies: ☐ **Evaluation/Consultation**	☐ **Listing**
Has the member had an evaluation/consultation? ☐ Yes (list date of evaluation/consultation)	☐ No (indicate scheduled date)
Has the member been listed? ☐ Yes (indicate date of listing)	☐ No
Transplant type	
Is the member currently inpatient at the transplant facility?	☐ Yes ☐ No
Type of transplant:	
Primary diagnosis:	ICD-9/10 :
Procedure (CPT):	Code description:
For kidney transplant, is the member on dialysis? ☐ Yes (please indicate start date)	☐ No
For lung transplant, please indicate: ☐ Single ☐ Double	
For bone marrow transplant, please indicate: ☐ Auto ☐ Allo - related ☐ Other:	☐ Allo - unrelated ☐ Allo - unspecified
Please submit any clinical documentation that supports your request for this transplant	

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