Transplant Referral Form

Notification Only: Notification and Request for Network Assistance:

Submitted By: ______ Phone Number: ______ Referral Date: ______

Email Address: ______ Account Name / Policyholder: ______

EMPLOYEE / PATIENT INFORMATION:

Patient Name: ______ Member ID#: ______

Date of Birth: ______ Patient Effective Date: ______ Gender: ______

Patient Address: ______

Population: Commercial Medicare Medicaid

Policy Year: Claims Paid to Date: $ ______ Claims Pended: $ ______

CASE MANAGEMENT INFORMATION:

Contact Name: ______ Company Name: ______

Email: ______ Phone: ______

Facility Name: ______ City: ______ State: ______

ICD-10 Code: ______ Diagnosis: ______

Transplant Type: ______ Evaluation Date: ______

Transplant Network: ______ Direct Contract: ______

Currently on Dialysis: Yes No Start Date: ______

BILLING / CLAIMS INFORMATION:

Claims Contact: ______ Phone: ______

Email Address: ______ Address: ______

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