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: ☐ Male ☐ Female

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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