HealthPartners®

Please Fax To (952)853-8713 For Questions Call (952)883-6333

Transplant Consult, Listing and Annual Evaluation Medical Review Form

The Transplant program must submit this form:

- Prior to consult visit and at time of listing or conditioning & treatment (Blood & Marrow)
- When a patient changes insurance carrier
- At the annual evaluation when patient is part of a focused network product
  - **Call member services for network product information**

Patient Information	
Name:	Member ID #:
DOB:	
Form completed by:	
Name:	Clinic/Facility:
Fax # for reply:	Phone #:
Transplant Physician	
Physician:(last name)	(first name)
Tax ID #:	Phone #
Fax #	
Transplant Facility	
Name	Tax ID #:
City	State
Phone #	Fax #
Request for: ☐Pre-consult evaluation visit ☐Evaluation/Consultation ☐Listing ☐Annual follow-up visit	
Is the member currently inpatient at the transplant facility? ☐ Yes ☐ No	
Has the member had a consultation? ☐ Yes ,date of consultation ☐ No, scheduled date	
Has the member been Listed? ☐ Yes, date of listing ☐ No	
Transplant Type:	
Is the member currently inpatient at the transplant facility? ☐ Yes ☐ No	
Type of Transplant	
Primary Diagnosis: ICD9/10 :	
Procedure (CPT) Code Description	
For Lung transplant, please indicate: ☐Single ☐Double	
For Bone Marrow Transplant, please indicate: ☐ Auto ☐ Allo related ☐ Allo–unrelated ☐ Allo- unspecified ☐ Umbilical Cord Blood ☐ Other:	
Please submit any clinical documentation that supports your request for this transplant	