HealthPartners

Prior Authorization Form

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

Transplant Consult and Listing

Patient	Vendor information
Patient Name:	Facility:
HealthPartners ID #:	Tax ID#:
DOB:	Phone #:
	Fax #:
	Form Completed By:
Transplant Physician:_____	Specialty/Primary Physician:_____

Used by HealthPartners Center of Excellence(COE) facilities only:

☐ Prior Notification

☐ Prior Authorization (medical documentation is needed for prior authorizations)

Consult office visit information

Date of Consult:_____ Type of Transplant_____

Diagnosis:_____ICD9 Code:_____

Procedure Code:(CPT4)_____

Transplant Listing information

Date of Listing_____ Type of Transplant_____

Diagnosis:_____ICD9 Code:_____

Procedure Code:(CPT4)_____

To check status of this request call member services at 952-883-5000
or log on to www.healthpartners.com/provider to access the Provider Portal.