

Preauthorization Transplant Request

Fax completed form to: 717.346.6870

SECTION I—Member Information		
Member Name:	Member ID:	Date of Birth:
Plan Type:	<input type="checkbox"/> Traditional <input type="checkbox"/> BlueJourney PPO <input type="checkbox"/> PPO <input type="checkbox"/> Comprehensive <input type="checkbox"/> BlueJourney HMO <input type="checkbox"/> POS <input type="checkbox"/> Keystone Health Plan® Central, Inc.	
Does member have other primary insurance? <input type="checkbox"/> N/A <input type="checkbox"/> Workers' Comp <input type="checkbox"/> Auto <input type="checkbox"/> Other:		
SECTION II—Authorization		
Level of Urgency:		
<input type="checkbox"/> Standard Request (Routine Care)—Care/treatment that is not emergent, urgent, or preventive in nature. <input type="checkbox"/> Expedited Request—Care/treatment that is emergent or the application of the timeframe for making Standard/Routine or nonlife-threatening care determinations: <ul style="list-style-type: none"> • Could seriously jeopardize the life, health, or safety of the member or others, due to the member's psychological state, or • In the opinion of the practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request. 		
Type of Transplant:	<input type="checkbox"/> Bone Marrow/Stem Cell <input type="checkbox"/> Kidney <input type="checkbox"/> Liver <input type="checkbox"/> Heart <input type="checkbox"/> Lung <input type="checkbox"/> Liver/Kidney <input type="checkbox"/> Pancreas <input type="checkbox"/> Pancreas/Kidney Simultaneous <input type="checkbox"/> Heart/Lung	
Donor Information (if applicable): Name:		Date of Birth:
Choose One:	<input type="checkbox"/> Transplant Evaluation Phase Start Date: <input type="checkbox"/> Transplant Listing Start Date: <input type="checkbox"/> Scheduled Inpatient Transplant Procedure Date of Admission: <input type="checkbox"/> Scheduled Outpatient Transplant Procedure Date of Service:	
Primary Diagnosis:		Additional Diagnosis:
Primary Procedure Codes:		
SECTION III—Servicing Facility Information		
Servicing Facility Name:		Facility NPI:
Servicing Address:		
Servicing City:	Servicing State:	Servicing ZIP Code:
Contact Name:	Contact Phone:	Fax:
Out-of-Network Reason (if applicable):	<input type="checkbox"/> Continuity of Care <input type="checkbox"/> Court Ordered <input type="checkbox"/> Employer Request	
	<input type="checkbox"/> ER Admit <input type="checkbox"/> Facility Not Available <input type="checkbox"/> Patient Out-of-Area	
	<input type="checkbox"/> Patient Request <input type="checkbox"/> Primary Care Physician Not Available	
	<input type="checkbox"/> Provider Request <input type="checkbox"/> Specialist Not Available <input type="checkbox"/> State Requirements	
SECTION IV—Admitting Provider Information		
Requesting Provider Full Name (M.D.):		Requesting Provider NPI:
Requesting Address:		
Requesting City:	Requesting State:	Requesting ZIP Code:
Contact Name:	Contact Phone:	Fax:
<input type="checkbox"/> Local Blue Plan (if yes, please provide local Blue Plan identification)		
SECTION V—Additional Information		
<input type="checkbox"/> Please attach to this coversheet the most recent H&P, progress notes, diagnostic studies, and any other clinical documentation related to this request.		
Any questions, contact Capital BlueCross Preauthorization department at 800.471.2242		
SECTION VI—Physician Signature		
Please Sign:		Date:

(Preauthorization is not a guarantee of payment.)