Preauthorization Transplant Request

Fax completed form to: 717.346.6870

SECTION I—Member Information

Member Name:		Member ID:	Date of Birth:
Plan Type:	☐ Traditional ☐ Medicare Advantage PPO ☐ PPO ☐ Comprehensive ☐ Medicare Advantage HMO ☐ POS ☐ Keystone Health Plan® Central, Inc.		
Does Member have other primary insurance? ☐ N/A ☐ Workers' Comp ☐ Auto ☐ Other:			

SECTION II—Authorization

Level of Urgency:

☐ **Standard** Request (Routine Care)—Care/treatment that is not emergent, urgent, or preventive in nature.

☐ **Expedited** Request—Care/treatment that is emergent or the application of the timeframe for making standard/routine or nonlife-threatening care determinations:

- 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:	☐ Bone Marrow/Stem Cell ☐ Kidney ☐ Liver ☐ Heart ☐ Lung ☐ Liver/Kidney ☐ Pancreas ☐ Pancreas/Kidney Simultaneous ☐ Heart/Lung	
Donor Information (if applicable): Name:		Date of Birth:
Choose One:	☐ Transplant Evaluation Phase Start Date:	
	☐ Transplant Listing Start Date:	
	☐ Scheduled Inpatient Transplant Procedure Date of Admission:	
	☐ 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):	☐ Continuity of ☐ Court ☐ Employer Request ☐ ER ☐ Facility Not Available ☐ Patient Out-of-Area ☐ Patient Request ☐ Primary Care Physician Not Available ☐ Provider ☐ Specialist Not Available ☐ 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:
☐ Local Blue Plan (if yes, please provide local Blue Plan identification)		

SECTION V—Additional Information

☐ 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 Blue Cross Preauthorization department at 800.471.2242

SECTION VI—Physician Signature

Please Sign:	Date:

(Preauthorization is not a guarantee of payment.)