



Transplant Pre-Certification/Pre-Authorization Request Form

Date: _____

Facility Information		Ordering/Attending Provider	
Facility Name:		Provider Name:	
Address:		Address:	
City/ State/ Zip:		City/ State/ Zip:	
NPI:		NPI:	
Provider #:		Provider #:	
Contact Name:		Contact Name:	
Phone #:	()	Phone #:	()
Fax #:	()	Fax #:	()
Patient Information			
Patient Name:		DOB:	
ID #:		Group #:	
Address:		Phone #:	()
City/ State/ Zip:		Diagnosis:	
Other insurance:	<input type="checkbox"/> Commercial <input type="checkbox"/> Medicare		
<input type="checkbox"/> Organ: <small>(please specify type)</small>		<input type="checkbox"/> Living donor <input type="checkbox"/> Deceased donor	
<input type="checkbox"/> Bone Marrow		<input type="checkbox"/> Autologous	
<input type="checkbox"/> Peripheral Stem Cell		<input type="checkbox"/> Allogeneic <input type="checkbox"/> Myeloablative <input type="checkbox"/> Non-myeloablative	
<input type="checkbox"/> Cord Blood		<input type="checkbox"/> Related <input type="checkbox"/> Unrelated	
Facility Status for Specific Transplant Type		<input type="checkbox"/> BDCT <input type="checkbox"/> Alt. Model BDCT	
		<input type="checkbox"/> Par with Local Blue Plan <input type="checkbox"/> Non-Par	

Total Pages Faxed: _____

Signature of Provider representative

Fax form to: (651)662-1624, or Mail form to: Integrated Health Management, Attn: Transplant Coordinator, PO Box 64179, St Paul, Minnesota 55164-0179