Medicare Advantage Transplant Referral Form

HealthSpring℠

Complete this editable referral form and fax it to **866-287-5834**. This form is for use by health care professionals **only** for referral of a Medicare Advantage covered member for transplantation.

* Indicates a **required** field.

Date / /	* Name of person making referral	* Callback number

FACILITY INFORMATION

* Name	* Phone		
* Address	* City	* State	* ZIP
* Taxpayer identification number	* National Provider Identifier	* Financial coordinator	* Financial coordinator fax

* Member name	* Date of birth / /	* Member's ID number	
* Employer	* Member phone (include area code if available)		
* Member address	* City	* State	* ZIP

TRANSPLANT INFORMATION

* **Zone request**			
☐ Zone 1 (evaluation – outpatient only)	☐ Zone 2 (listing – outpatient only)	☐ Zone 3 (transplant procedure) ☐ Inpatient ☐ Outpatient	☐ Zone 4 (post transplant – outpatient only) Date / /

* Transplant type or ventricular assist device; include Current Procedural Terminology (CPT®) code
* Diagnosis and diagnosis code

* Has member started evaluation? ☐ Yes ☐ No	If so, when?

If bone marrow transplant ☐ Auto ☐ Related ☐ Unrelated

If lung transplant ☐ Single ☐ Double

Other insurance? ☐ Yes ☐ No If so, what company?_____

Who is the primary carrier?_____

Verify standard versus expedited? _____