

Transplant Evaluation Request
Referral Worksheet
Attn: Transplant Case Manager
800-891-2520 Fax 567-661-0842



ELITE ☐

COMMERCIAL/HMO ☐

PATIENT INFORMATION

Member Name _____
DOB _____
Phone Number _____

Paramount ID# _____
Paramount Secondary ID#: _____
(if applicable)

REFERRAL SOURCE

Referral Organization: _____
NPI: _____
Federal ID (Medicaid or Medicare): _____
Fax: _____

Ordering Physician: _____
Provider Billing Tax ID (TIN): _____
Phone: _____
Contact Person: _____

TREATING PHYSICIAN

Treating Physician: _____
NPI: _____
Federal ID: _____
Fax: _____

Facility: _____
Provider Tax ID (TIN): _____
Phone: _____
Date of Evaluation: _____

DIAGNOSIS

Primary Diagnosis: _____
Secondary Diagnosis: _____

ICD-10 Code: _____
ICD-10 Code: _____

PRE-TRANSPLANT EVALUATION DIAGNOSTIC TESTS/PROCEDURES REQUESTED

Office Evaluations: _____

Diagnostic/Procedure: _____
Diagnostic/Procedure: _____
Diagnostic/Procedure: _____
Diagnostic/Procedure: _____
Diagnostic/Procedure: _____
Diagnostic/Procedure: _____
Diagnostic/Procedure: _____

CPT Code: _____
CPT Code: _____
CPT Code: _____
CPT Code: _____
CPT Code: _____
CPT Code: _____
CPT Code: _____

TRANSPLANT PROCEDURE

Transplant Procedure Type: _____

CPT Code: _____

Please submit with this request:

- Medical/clinical history
- Results of any pertinent diagnostic testing
- Treatment plan

Confidentiality Notice

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