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

PARAMOUNT
ELITE | COMMERCIAL/HMO

ELITE ☐ COMMERCIAL/HMO ☐

PATIENT INFORMATION

Member Name _____ Paramount ID# _____
DOB _____ Paramount Secondary ID#:_____
Phone Number _____ (if applicable)

REFERRAL SOURCE

Referral Organization: _____ Ordering Physician: _____
NPI: _____ Provider Billing Tax ID (TIN): _____
Federal ID (Medicaid or Medicare): _____ Phone: _____
Fax: _____ Contact Person: _____

TREATING PHYSICIAN

Treating Physician: _____ Facility: _____
NPI: _____ Provider Tax ID (TIN): _____
Federal ID: _____ Phone: _____
Fax: _____ Date of Evaluation: _____

DIAGNOSIS

Primary Diagnosis: _____ ICD-10 Code: _____
Secondary Diagnosis: _____ ICD-10 Code: _____

PRE-TRANSPLANT EVALUATION DIAGNOSITIC TESTS/PROCEDURES REQUESTED

Office Evaluations: _____

Diagnostic/Procedure: _____ CPT Code:_____
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TRANSPLANT PROCEDURE

Transplant Procedure Type: _____ CPT Code: _____

Please submit with this request:

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

Revised Date: 5/2024