ORGAN TRANSPLANT AUTHORIZATION REQUEST FORM

Member Name _____
Member Number _____
Member Date of Birth _____
WTCHP Certified Condition(s) [ICD-9 code(s) and Description(s)] _____

Name of Requestor _____
Title of Requestor _____
Telephone Number of Requestor _____
Email Address of Requestor _____
Date of Request _____

PART A: REQUEST FOR TESTING

Organ transplant requested (code and description) _____
Diagnosis for which transplant is requested (code and description) _____
Pre-surgery procedures for which authorization is requested (code and description)
_____
_____
_____

WTCHP Action: APPROVE _____ DENY _____

PART B: TRANSPLANT FACILITY

Transplant Surgeon Name _____
Transplant Surgeon NPI _____
Transplant Facility Name and Location _____
Transplant Facility NPI _____
Transplant Coordinator Name and Telephone Number _____
Referring Physician Name and Address _____

WTCHP Action: APPROVE _____ DENY _____

PART C: REQUEST FOR TRANSPLANT

Organ transplant requested (code and description) _____

Summary of pre-surgical testing:

Recommendations of transplant board:

Proposed date of surgery _____

WTCHP Action: APPROVE _____ DENY _____