Transplant Prior Authorization Request Form

Effective May 1, 2019, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) providers are required to use the Availity Essentials® Provider Portal to submit preservice prior authorization requests. **Faxes and phone calls for these requests will no longer be accepted by Blue Cross.** Please complete the clinical sections on this form and attach it to your request at Availity.com/essentials to ensure a timely review.

Providers outside of Minnesota without electronic access can fax this form, along with clinical records to support the request, to (651) 662-1624.

☐ **Request for Urgent Review:** By checking this box, I certify that applying the standard review time may seriously jeopardize the life or health of the member or the member's ability to regain maximum function per federal definition of "Urgent."

Patient Information

Member ID number: ______________________ Group ID number: ______________

Member name: ______________________ Date of birth: ______________

Member address: ______________________

Member city/state/ZIP: ______________________

Phone: ______________ Other insurance: ☐ Commercial ☐ Medicare

Facility Information

Person completing form: ______________________

Phone: ______________ Fax: ______________

Facility NPI/Tax ID: ______________ Facility provider ID: ______________

Facility name: ______________________

Facility address: ______________________

Facility city/state/ZIP: ______________________

Facility status: ☐ BDCT ☐ Alternate Model BDCT ☐ Participating with local Blue plan ☐ Non-Par

Ordering/Attending Provider Information

Individual ID : ______________ NPI/Tax ID:______________

Provider name: ______________________

Provider address: ______________________

Provider city/state/ZIP: ______________________

Phone: ______________ Fax: ______________

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X18539R04 (03/22)

Transplant Information

Procedure code(s) requested: ______________________________

Procedure code(s) description: ______________________________

Primary diagnosis code: ____________________ Secondary diagnosis code: ____________________

Transplant type

☐ **Organ**

Organ type: ______________ Donor type: ☐ Living ☐ Deceased

☐ **Stem Cell**

Source: ☐ Bone marrow ☐ Peripheral stem cell ☐ Cord blood

Type: ☐ Autologous ☐ Autologous islet cell ☐ Allogeneic ☐ Allogeneic islet cell

Allogeneic type: ☐ Myeloablative ☐ Non-myeloablative

Allogeneic donor: ☐ Related ☐ Unrelated

Total pages: ________ Signature of Provider Representative: ______________________________