

Attachment Form A1: Transplant Services Notification Form

When filling out this form:

- Use the tab key to go from field to field.
- Print and sign this form.

Referring plan:					
Patient name:		Patient ID:		Date of birth:	
Group name/ID number:		Subscriber name/ID number:			
Primary insurance carrier name:					
Secondary insurance carrier:					
Transplant type (please check all that apply)					
Bone marrow stem cell	Patient diagnosis:				
Type:	Autologous <input type="checkbox"/> Allogeneic <input type="checkbox"/> "Mini" allogeneic <input type="checkbox"/> Tandem #1 <input type="checkbox"/> Tandem #2 <input type="checkbox"/>				
Cell source:	Bone marrow <input type="checkbox"/> Peripheral blood stem cell <input type="checkbox"/> Cord blood <input type="checkbox"/>				
Donor (if allogenic):	Related <input type="checkbox"/> Unrelated <input type="checkbox"/> Matched <input type="checkbox"/> Mismatched <input type="checkbox"/>				
Solid organ	Patient diagnosis:				
Organ type:	Initial transplant <input type="checkbox"/> Re-transplant <input type="checkbox"/>				
Donor:	Cadaveric <input type="checkbox"/> Living donor <input type="checkbox"/>				
Transplant hospital name:					
Transplant hospital address:					

This patient meets the medical necessity guidelines of Anthem Blue Cross and Blue Shield (Anthem) for the above noted transplant, for included transplant service. All eligible transplant services and global/outlier rates are listed in the Centers of Medical Excellence Hospital Participation Agreement.

Contact:		at:		for precertification and to verify continued eligibility for medical benefits prior to beginning CME Transplant Services.	
Authorized plan representative signature:					
Title:		Exp. Date:		Print name:	
Area code + phone number:		Fax number:			
Contact:		at:		For Case Management Services.	

Hospital: Submit bundled, global claim (including the CME Attachment C or D), and a copy of this Attachment Form A1: Transplant Services Notification Form to:

Name:		Address:		Phone number:	
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Please reconfirm this plan claim contact information prior to submitting bundled global claim. Hospital is to collect any applicable coinsurance, deductibles, and co-payments. **Plan:** Provide any additional information or special instructions below (i.e., LTM, COB, deductibles, co-payments, etc.)

<https://mediproviders.anthem.com/wi>