

Transplant Related PA Request



Chart Notes Required

Please fax this request to: 503-574-6464 or 800-989-7479 Please call our PA department if you have any questions at: 503-574-6400 or 800-638-0449

For High Tech Imaging	Registration: Providence PIN#: 045-83169			
		Member Information		
Last Name:		First Name:		
Insurance ID#:		DOB:		
Address:				
		Provider Information		
Primary Care Physician (PCP):				
Requesting Provi	der:		TIN#:	
Address:				
Servicing Provider:			TIN#:	
Address:			NPI#:	
Servicing Facility:			TIN#:	
Address:			NPI#:	
		Request Information	·	
ICD-10 Code(s):				
CPT Code(s):				
Transplant Services:				
☐ HLA Typing Related: Y or N Relationship: Nan ☐ Comprehensive Transplant Evaluation (Includes labs not on PA list			DOB	
If living donor for solid organ transplant, include name of potential donor:				
☐ Bone Marrow Biopsy (Includes proc and cytology codes)				
☐ Transplant ☐ Annual Post-Transplant Follow-up				
	Wait List Management ☐ Transplant Center Referral Initial Post-Transplant Follow-up ☐ Type of Transplant being considered:			
DOS:		Date Span Req	Date Span Requested:	
Comments:				
	REQU	IRED Contact Infor	mation:	
Name:		Phone#:	Phone#:	
Fax#:		Total# of pages	Total# of pages faxed, including cover page:	
	PEDITE! The provider believes the, health or ability to regain maxing	_	under the standard time frame could place the jeopardy (CMS definition)	

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6/14/2023