of Tennessee

Commercial/FEP Transplant Request Form

Please fax this completed form to:

BlueCross BlueShield of Tennessee Commercial/FEP Transplant
Fax: **423-535-5260**

Date Submitted: ___ / ___ / _____

Number of Pages Attached (include cover and/or form): _____

Transplant Coordinator Contact

Name: _____

Phone Number:_____ Fax Number: _____

Please be sure contact fax number is clear due to HIPAA, since decision letters may be faxed to the provider.

With each type of transplant, please include history and physical, and psychosocial evaluation.

Please see needed criteria for each type of transplant and include these and all pertinent clinical information.

Member Information

Name: _____

ID Number:_____ Date of Birth:____/ ____/ _____

Phone Number:_____

Diagnosis (including ICD-10 Code):

Continued on next page

Procedure code(s):

Facility Information

Name: _____

NPI Number: _____ Provider Number: _____

Requesting Provider Information

Requesting Provider: _____

Provider Number: _____ NPI Number: _____

Phone Number: _____ Fax Number: _____

Address: _____

City: _____ State: _____ ZIP: _____

Transplant Information

Transplant Type: _____

Evaluation Date: ___ / ___ / _____

Initial Inpatient ☐ Yes ☐ No

Transplant Scheduled ☐ Yes ☐ No

Will transplant be performed: ☐ Inpatient ☐ Outpatient

Committee Approval Date: ___ / ___ / _____

Continued on next page

Stem Cell Transplant

Is transplant related to a clinical trial? ☐ Yes ☐ No

Tentative infusion/transplant date: ___ / ___ / _____

What is the mobilization date? ___ / ___ / _____

Stem cell type: ☐ Autologous ☐ Allogeneic

What is the harvesting date?___ / ___ / _____

If allogeneic matched donor, then what is the name of donor?

_____

What is the date(s) for IV ablation/high dose chemotherapy?

___ / ___ / _____ ___ / ___ / _____

Comments:

Liver Transplant

MELD score or PELD score if applicable: _____

Does patient have ongoing alcohol, tobacco and/or substance use? ☐ Yes ☐ No

Does patient have a diagnosis of Intrahepatic cholangiocarcinoma, Neuroendocrine tumors metastatic to liver, or Hepatocellular carcinoma that has extended beyond the liver?

☐ Yes ☐ No

Continued on next page

Comments:

Kidney Transplant

Creatinine Level: _____

Glomerular Filtration Rate:_____

Does patient have a history of cancer? ☐ Yes ☐ No

Does patient have diabetes? ☐ Yes ☐ No

Living or deceased donor? ☐ Living donor ☐ Deceased donor

Comments:

Heart Transplant

What are the indications for cardiac transplant?

Continued on next page

Comments:

Lung and Lobar Lung Transplant

Does patient have end-stage pulmonary disease? ☐ Yes ☐ No

Comments:

Allogeneic Pancreas Transplant

What are the indications for pancreas transplant?

Comments:

Continued on next page

Total Artificial Hearts and Implantable Ventricular Assist Device

Is this bridge to transplant? ☐ Yes ☐ No

Is this destination therapy? ☐ Yes ☐ No

What is the New York Heart Association Class? _____

Does patient have ongoing alcohol, tobacco, or substance use? ☐ Yes ☐ No

Does patient have end stage organ damage? ☐ Yes ☐ No

Does patient have sufficient space in the thoracic and/or abdominal cavity for the device?

☐ Yes ☐ No

By submitting this request, you're confirming that you've provided all clinical information available pertinent to this request and you're requesting the decision be made based on information provided in your submission.

Contact the eBusiness Marketing team for all your Availity® registration and training needs by calling **423-535-5717 option 2** or emailing to: **eBusiness_marketing@bcbst.com**.

24PED2801900 (08/24)