CONSUMERS MUTUAL
INSURANCE of MICHIGAN

877-472-5495

Prior Authorization Form

Fax Form To: 317-284-7473

Transplant Organs

Member

Last Name: ______________________ First Name: ______________________

ID #: ______________________ DOB: ______________________

Organ(s): ______________________

☐ Transplant Evaluation

Date of service: ______________________ Diagnosis code(s): ______________________

Primary diagnosis description: ______________________

☐ Transplant Listing

☐ Transplanting institution's selection criteria has been met.

☐ Kidney ☐ Heart ☐ Lung ☐ Pancreas Transplant Alone (PTA) ☐ Corneal

For the transplants listed below, Consumers Mutual's criteria must be met in addition to the transplanting institution's selection criteria. Please see Transplant Organs medical policy.

☐ Liver ☐ Bone Marrow/Peripheral Stem Cell (see Specific form list) ☐ Intestinal/Small Bowel

For VADs and Artificial Hearts used as a bridge to transplant (BTT), Consumers Mutual's criteria must be met. Please see Ventricular Assist Devices & Artificial Hearts medical policy. An advanced care planning assessment (see Appendix A at the end of the medical policy) should be completed by a qualified provider and accompany the request for a VAD or artificial heart.

☐ BTT VAD ☐ BTT Artificial Heart

☐ **Admission for Transplant**

Date of admission: ______________________ Date of transplant: ______________________

Primary procedure description: ______________________

Procedure code(s) (CPT): ______________________

Requested by:

Provider Name: ______________________ Phone: ______________ Fax: ______________

Provider Tax ID: ______________________ Specialty: ______________________

Address: ______________________

Contact Name: ______________________

Directed to:

Provider Name: ______________________ Facility: ______________________

Provider Tax ID: ______________________ Facility Tax ID: ______________________

Address: ______________________ Address: ______________________

______________________ ______________________

Phone: ______________ Fax: ______________ Phone: ______________ Fax: ______________

Contact Name: ______________________ Contact Name: ______________________

Other indications not listed above: ______________________

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*****ALL FIELDS MUST BE COMPLETE AND LEGIBLE FOR PRIOR AUTHORIZATION REVIEW*****

Clinical documentation may be requested at discretion of health plan.