



TRANSPLANT PRE-SERVICE REQUEST
Date: _____

Mail form to: Transplant Unit, Route 472 P.O. Box 64265; St. Paul, Minnesota 55164-0265

Fax form to: 651-662-1624

Facility Information

Facility Name:
Address:
City/State/Zip:
NPI:
Contact Name:
Phone #:
Fax #:

Patient Information

Patient Name:	Subscriber/Enrollee:
DOB:	Group Number:
Address:	Identification Number:
	Phone #
Diagnosis:	
Other Insurance: <input type="checkbox"/> Commercial <input type="checkbox"/> Medicare	

<input type="checkbox"/> Organ: (please specify type)	<input type="checkbox"/> Living donor <input type="checkbox"/> Deceased donor
<input type="checkbox"/> Bone Marrow	<input type="checkbox"/> Autologous
<input type="checkbox"/> Peripheral Stem Cell	<input type="checkbox"/> Allogeneic
<input type="checkbox"/> Cord Blood	
<input type="checkbox"/> LVAD	<input type="checkbox"/> Bridge to transplant <input type="checkbox"/> Destination therapy

Total Pages Faxed: ____ Signature of Provider Representative _____

*****Please attach relevant medical documentation*****
*****For prompt processing of your request – please complete ALL fields*****