BlueLink TPA

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Transplant Pre-Certification/Pre-Authorization Request Form

Date:_______

Facility Information		**Ordering/Attending Provider**	
Facility Name:		Provider Name:	
Address:		Address:	
City/ State/ Zip:		City/ State/ Zip:	
NPI:		NPI:	
Provider #:		Provider #:	
Contact Name:		Contact Name:	
Phone #:	( )	Phone #:	( )
Fax #:	( )	Fax #:	( )

Patient Information			
Patient Name:		DOB:	
ID #:		Group #:	
Address:		Phone #:	( )
City/ State/ Zip:		Diagnosis:	
Other insurance:	☐ Commercial ☐ Medicare		

☐ **Organ:** (please specify type)	☐ Living donor ☐ Deceased donor
☐ **Bone Marrow** ☐ **Peripheral Stem Cell** ☐ **Cord Blood**	☐ Autologous ☐ Allogeneic ☐ Myeloablative ☐ Non-myeloablative ☐ Related ☐ Unrelated
Facility Status for Specific Transplant Type	☐ BDCT ☐ Alt. Model BDCT ☐ Par with Local Blue Plan ☐ Non-Par

Total Pages Faxed:_____

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Signature of Provider representative

Fax form to: (651)662-1624, or Mail form to: Integrated Health Management, Attn: Transplant Coordinator, PO Box 64179, St Paul, Minnesota 55164-0179