

Transplant Prior Authorization Request

****Chart Notes Required****

Please fax to 503.850.9398 | Questions call YCCO Customer Service 855.722.8205

For High Tech Imaging	eviCore Phone: 800.918.8924 https://www.evicore.com/ For Registration: https://www.evicore.com/resources/healthplan/yamhill	
Expedited Request, Out of Network Benefits, or Out of Network Providers must complete the required sections		
Member Information		
Last Name:	First Name:	
Insurance ID #:	DOB:	
Address:		
REQUIRED Contact Information		
Name:	Phone:	Fax:
Primary Care Physician (PCP):		
Requesting Provider:		TIN#:
Address:		NPI#:
Servicing Provider:		TIN#:
Address:		NPI#:
Do you have an active DMAP #: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress Note: All DMAP administrative rules, guidelines, and applications to become an enrolled DMAP provider can be found at www.oregon.gov/OHA/healthplan .		
Servicing Facility:		TIN#:
Address:		NPI#:
Do you have an active DMAP #: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress Note: All DMAP administrative rules, guidelines, and applications to become an enrolled DMAP provider can be found at www.oregon.gov/OHA/healthplan .		
Request Information – Provider Must Supply the Service Codes Requested for the Transplant		
ICD-10 Code(s):		CPT Code(s):
Transplant Services:		
<input type="checkbox"/> HLA Typing Related: <input type="checkbox"/> Yes or <input type="checkbox"/> No Relationship: _____ Name: _____ DOB: _____ <input type="checkbox"/> Comprehensive Transplant Evaluation (Includes labs not on PA list) If living donor for solid organ transplant, include name of potential donor: _____ <input type="checkbox"/> Bone Marrow Biopsy (Includes proc and cytology codes) <input type="checkbox"/> Transplant <input type="checkbox"/> Annual Post-Transplant Follow-up		

<input type="checkbox"/> Transplant Center Referral	
<input type="checkbox"/> Type of Transplant Being Considered: _____	
<input type="checkbox"/> Wait List Management	
<input type="checkbox"/> Initial Post-Transplant Follow-up	
Date of Service:	Date Span Requested:
Comments:	
<p>Expedite- defined as member's life, health, or ability to regain maximum function is in serious jeopardy if determination is not made in the standard time frame. Request must include supporting documentation to substantiate an expedited review.</p> <p>Explanation Required:</p>	

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