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 #: ☐ Yes ☐ No ☐ 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 #: ☐ Yes ☐ No ☐ 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:

☐HLA Typing Related: ☐Yes or ☐No Relationship:_____ Name:_____ DOB:_____

☐Comprehensive Transplant Evaluation (Includes labs not on PA list)

If living donor for solid organ transplant, include name of potential donor:_____

☐Bone Marrow Biopsy (Includes proc and cytology codes)

☐Transplant

☐Annual Post-Transplant Follow-up

☐Transplant Center Referral

☐Type of Transplant Being Considered:_____

☐Wait List Management

☐Initial Post-Transplant Follow-up

Date of Service:	**Date Span Requested:**

Comments:

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.**
Explanation Required:

12/12/2023