UNICARE
An Anthem Company

Form A1:
Transplant Services Notification Form

State of Residence

Referring UniCare Plan

Patient Name | Patient ID # | Date of Birth

Group Name / ID Number | Subscriber Name / ID Number

Primary Insurance Carrier Name | Secondary Insurance Carrier Name

TRANSPLANT TYPE (please check all that apply)

BONE MARROW / STEM CELL **Patient Diagnosis:** _____

Type: Autologous ☐ Allogeneic ☐ "Mini" Allogeneic ☐ Tandem: #1 ☐ Tandem: #2 ☐

Cell Source: Bone Marrow ☐ Peripheral Blood Stem Cell ☐ Cord Blood ☐

Donor (If Allogeneic): Related ☐ Unrelated ☐ Matched ☐ Mismatched ☐

SOLID ORGAN **Patient Diagnosis:** _____

Organ Type: _____ Initial Transplant ☐ Re-transplant ☐ **Donor:** Cadaveric ☐ Living Donor ☐

Transplant Hospital Name | Transplant Hospital Address

This patient meets the Medical Necessity guidelines of _____ (name of UniCare Plan) for the above noted transplant, for included Transplant Service. All eligible Transplant Services and Global/Outlier Rates are listed in the Centers of Medical Excellence Hospital Participation Agreement.

Contact: _____ at _____ for precertification and to verify continued eligibility for medical benefits prior to beginning CME Transplant Services.

Authorized Plan Representative Signature | Title | Expiration Date

Print Name | Area Code + Phone Number | Fax Number

Contact: _____ at _____ for Case Management Services

Hospital: Submit bundled, GLOBAL CLAIM (including the CME Attachment C or D), and a copy of this *CME Attachment A1: Transplant Services Notification Form* to:

Name | Address / Phone Number

(Please reconfirm this Plan claim contact information prior to submitting bundled global claim. Hospital is to collect any applicable coinsurance, deductibles, and copayments.)

Plan: Provide any additional information or special instructions below (i.e., LTM, COB, deductibles, copayments, etc.):