UniCare
An Anthem Company

Form A2:
Hospital Notification of Transplant Admission Form

Date: ________________________

Member

To: Transplant Claim Unit

Fax #: ______________________________________

Phone #: ____________________________________

From:

Name: ____ Institution: ___________________________________

Phone #: ____ Fax #: _______________________________________

Patient Name	Patient ID #	Date of Birth

NOTE: Please complete a separate *Hospital Notification of Transplant Admission Form* for each transplant.

Solid Organ Transplant

Solid Organ Type: _______________________________________ Diagnosis: ___________________________________

Initial Transplant ☐ Re-transplant ☐ Cadaveric ☐ Living Donor ☐

Inpatient Admission Date: _________________________________ Inpatient Transplant Date: _________________________

UniCare CME Dates: ______________________________________ to: ____

Bone Marrow / Stem Cell Transplant

Diagnosis: ____

Check all that apply:

Autologous ☐ Allogeneic ☐ Mini Allogeneic ☐ Tandem #1 ☐

Tandem #2 ☐ Bone Marrow ☐ Peripheral Stem Cell ☐ Cord Blood ☐

Related ☐ Unrelated ☐ Matched ☐ Mismatched ☐

Mobilization Therapy Date(s): Inpatient ____________________________ Outpatient ______________________

Marrow/Stem Cell Harvesting Date(s): Inpatient ____________________________ Outpatient ______________________

Marrow Ablative Therapy Date(s): Inpatient ____________________________ Outpatient ______________________

Reinfusion/Transplant Date(s): Inpatient ____________________________ Outpatient ______________________

UniCare CME Dates: ____________________________________ to: _____________________________