P.O. BOX 11033, ORANGE, CA 92856 Phone: 714-246-8686

TRANSPLANT NOTIFICATION AND REQUEST FORM

*Transplants for children under the age of 21 also need a referral to California Children's Services (CCS)

Fax Submissions: Urgent: 714-796-6616 Routine: 714-796-6607

PHASE: ☐ New Referral ☐ Evaluation ☐ Listed ☐ Transplant ☐ Post-Transplant

***** IN ORDER TO PROCESS YOUR REQUEST, ARF MUST BE COMPLETED AND LEGIBLE *****

PROVIDER: Authorization does not guarantee payment; ELIGIBILITY must be verified at the time services are rendered.
CalOptima Health may redirect to an alternate Center of Excellence based on contract status or center availability

Patient Name: ______________________ ☐ M ☐ F **D.O.B.** ________ **Age:** ________
Last First

Mailing Address: ________________ **City:** ____________ **ZIP:** ________ **Phone:** ________

Client Index # (CIN): ______________ **Diagnosis:** ____________________ **ICD-10:** ________

Referring Provider:

Provider NPI#: ______________ **TIN#:** ______________

Medi-Cal ID#: _____________________

Address: **Phone:** ________

Fax: ________

Office Contact: ____________________

Physician's Signature: ____________________

TRANSPLANT TYPE

- ☐ BMT
- ☐ DLI
- ☐ Kidney
- ☐ Kidney Pancreas
- ☐ Liver
- ☐ Liver and Kidney
- ☐ Lung
- ☐ Heart
- ☐ Heart and Lung
- ☐ Small Bowel

Referred to Provider:

Provider NPI#: ______________ **TIN#:** ______________

Address: **Phone:** ________

Fax: ________

☐ **Inpatient** **Estimated Length of Stay:** ____________________

☐ **Outpatient** ☐ **Letter of Agreement (LOA) Requested**

Date(s) of Service: ____________________ **Retro Date(s) of Service:** ____________________

List ALL procedures requested along with the appropriate CPT/HCPCS

REQUESTED PROCEDURES	*CODE (CPT or HCPCS)*	*QUANTITY (REQUIRED)*