AmeriBen
CONFIDENTIAL

Transplant /Gene Therapy /Cellular Therapy Benefit Verification

To submit a Benefit Verification request, please complete the following information and fax all related clinical information to support the medical necessity of this request to AmeriBen Medical Management

Attn: Transplant Coordinator
Fax: 208-955-1502 Phone: 208-947-1366

Date Request Submitted

I. Patient Information:

Patient Name (First and Last)	*Date of Birth*	*Gender:* ◯ M ◯ F
Patient Address, Street, City, State, Zip		
Patient ID Number	*Patient Phone*	
Employee Name (First and Last)	*Employer Name*	

☐ See attached Face Sheet for Demographics

II. Transplant Benefits Requested

☐ Solid Organ (please indicate which organ/organs):

☐ Bone Marrow Stem Cell (please indicate type):

☐ Gene Therapy (please indicate medication being requested):

☐ Adoptive Cell Therapy (please indicate type) ◯ CAR-T ◯ TIL ◯ TCR T

Additional transplant medications requested:

Diagnosis Code/ICD10:

Surgical Transplant Code *(will be used throughout transplant process, including evaluation):*

Requested Dates for **EVALUATION** period: thru

◯ Outpatient ◯ Inpatient

Facility Rendering Care	
Facility Tax ID	*Facility NPI*
Facility Address, Street, City, State, Zip	
Facility Phone Number	*Facility FAX number*

III. Transplant Financial Coordinator or Designated Contact

Contact Name (First and Last)	
Phone Number	*FAX number*

◯ In Network Facility ◯ Out-of-Network ◯ Center of Excellence ◯ Blue Distinction Center

IV. Provider Overseeing transplant

Physician Name (First and Last)	
Physician Tax ID	*Physician NPI*
Physician Address, Street, City, State, Zip	
Physician Phone Number	*Physician FAX number*
Physician Representative	*Phone Number*

Important Information:

- Please attach clinical documentation to support transplant necessity.
- Benefit verification will be faxed upon completion
- To verify eligibility, network status and any issues regarding claims, please contact the dedicated toll free number on the member's ID card.