



## Transplant Benefit Verification FAX Request Form - CONFIDENTIAL

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: Jenny Bunn Fax # 208-955-1502**

**Phone: 208-955-1384**

Date Request Submitted: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: M / F

Address: \_\_\_\_\_

Patient ID Number: \_\_\_\_\_ Patient Phone: \_\_\_\_\_

Employee Name: \_\_\_\_\_ Employer Name: \_\_\_\_\_

See Attached Face Sheet for Demographics

**Type of transplant:** \_\_\_\_\_

Diagnosis Code/ICD 10(s): \_\_\_\_\_

Procedure/CPT Code(s) for transplant: \_\_\_\_\_

Requested Dates for Evaluation Period: \_\_\_\_\_

Outpatient       Inpatient

**Facility Rendering Care:** \_\_\_\_\_

Tax ID: \_\_\_\_\_ NPI: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**Transplant Financial Coordinator or designated contact:** \_\_\_\_\_ Phone Number: \_\_\_\_\_

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

Provider overseeing transplant: \_\_\_\_\_

Tax ID: \_\_\_\_\_ NPI: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Provider Contact Person: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**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 # on the member's ID card.**