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: Transplant Coordinator Fax # 208-955-1502

Phone: 208-947-1366

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):_____

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

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 (Specifically MD Name) _____

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.