Transplant Evaluation Request
Referral Worksheet
1-800-891-2520
Fax 1-567-661-0842

PATIENT INFORMATION

Member Name ___________________________________
DOB ___________________________________
Phone Number ______________________________
Paramount ID# ______________________________
Paramount Secondary ID#:_____________________
(if applicable)

REFERRAL SOURCE

Referral Organization: ___________________________________
NPI: ___________________________________
Federal ID (Medicaid or Medicare): ___________________________
Fax: ___________________________________
Ordering Physician: ______________________________
Provider Billing Tax ID (TIN): _______________________
Phone: ______________________________
Contact Person: ______________________________

TREATING PHYSICIAN

Treating Physician: ___________________________________
NPI: ___________________________________
Federal ID: ___________________________________
Fax: ___________________________________
Facility: ___________________________________
Provider Tax ID (TIN): ___________________________
Phone: ___________________________________
Date of Evaluation: ______________________________

DIAGNOSIS

Primary Diagnosis: ___________________________________
Secondary Diagnosis: ___________________________________
ICD-10 Code: ___________________________________
ICD-10 Code: ___________________________________

PRE-TRANSPLANT EVALUATION DIAGNOSITIC TESTS/PROCEDURES REQUESTED

Office Evaluations: ______________________________

Diagnostic/Procedure: ______________________________ CPT Code: ______________________________
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TRANSPLANT PROCEDURE

Transplant Procedure Type: ______________________ CPT Code: ______________________________

Please submit with this request:

- Medical/clinical history
- Results of any pertinent diagnostic testing
- Treatment plan

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