

# Cigna Medicare Advantage Transplant Referral Form



Complete this editable Referral Form found at [medicareproviders.cigna.com](http://medicareproviders.cigna.com) under the "Medicare Advantage" Forms and Practice Support > Prior Authorization Request Forms and fax it to **866.287.5834**. This form is for use by Health Care Professionals ONLY for referral of a Cigna Medicare Advantage covered individual for transplantation.

\* Indicates a **required** field.

<b>Date:</b>	* Name of person making referral:	* Call back number:	
* Patient's Name:	* Date of Birth:	* Member's ID Number:	
* Employer:	* Patient Phone: <i>(please include all available numbers)</i>		
* Patient's Address:	* City:	* State:	* Zip Code:

## FACILITY INFORMATION

* Name:	* Phone:		
* Patient's Address:	* City:	* State:	* Zip Code:
* TIN:	* NPI:	* Transplant coordinator:	* Phone:

## TRANSPLANT INFORMATION

<b>* Zone Request:</b> <input type="checkbox"/> Zone 1 (Evaluation); <input type="checkbox"/> Zone 2 (Listing); <input type="checkbox"/> Zone 3 (Transplant Procedure); <input type="checkbox"/> Zone 4 (Post Transplant); <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient            Date: _____			
* Transplant type or VAD (Include CPT code):		*Evaluation authorization request will include both 99245 and transplant specific CPT code.	
* Diagnosis and Diagnosis Code):			
* Has patient started evaluation?		If so, When?	
If heart transplant, is VAD needed? <input type="checkbox"/> Yes <input type="checkbox"/> No If bone marrow transplant ( <i>check applicable</i> ) <input type="checkbox"/> Auto <input type="checkbox"/> Allo <input type="checkbox"/> Related <input type="checkbox"/> Unrelated If lung transplant ( <i>check applicable</i> ) <input type="checkbox"/> Yes <input type="checkbox"/> No * Other Insurance?    If so, what company? _____ Who is the primary carrier? _____ Verify Standard vs Expedited? _____			

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