



### PERICO Specialty Claims Unit Transplant Referral Form

Referral Date \_\_\_\_\_

Submitted by: \_\_\_\_\_

Phone Number: \_\_\_\_\_ ext. \_\_\_\_\_

Group Name: \_\_\_\_\_

Policy Year: \_\_\_\_\_ Policy Status: \_\_\_\_\_

Group Specific: \$ \_\_\_\_\_

Lasered:\$ \_\_\_\_\_

Contract terms: \_\_\_\_\_

Split Fund: Y  N

Lifetime Max: \_\_\_\_\_

Transplant Limitations: \_\_\_\_\_

**EMPLOYEE/PATIENT INFORMATION**

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

SSN / ID#: \_\_\_\_\_

Patient Name: \_\_\_\_\_

SSN / ID#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Female  Male

Patient's Effective Date: \_\_\_\_\_

Primary  Secondary

Employee Active: Y  N  Other Coverage: Y  N  If Yes, what: \_\_\_\_\_

Policy Year (CPTD): \$ \_\_\_\_\_ Claims Pended: \$ \_\_\_\_\_

**MEDICAL/CASE MGMT INFORMATION**

Large Case Management Company: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_ ext. \_\_\_\_\_

Fax: \_\_\_\_\_ Email Address: \_\_\_\_\_

ICD-9 Code: \_\_\_\_\_ Diagnosis: \_\_\_\_\_ Evaluation Date: \_\_\_\_\_

Facility Name: \_\_\_\_\_ Transplant Type: \_\_\_\_\_

Is the Facility in the PPO Network: Y  N  Network Name: \_\_\_\_\_

**CLAIM INFORMATION**

Third Party Admin Name/ Location: \_\_\_\_\_

Txp Contract Contact \_\_\_\_\_ Phone Number: \_\_\_\_\_ ext. \_\_\_\_\_

Fax: \_\_\_\_\_

TPA Claims Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_ ext. \_\_\_\_\_

Fax: \_\_\_\_\_

*Please provide additional information below*

**COMMENTS**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**For Perico Life Specialty Claims Use Only**

Transplant Network Options

**Network Selection:**

Life Trac  URN  Interlink  Multiplan  Other \_\_\_\_\_