HEALTH SYSTEMS DIVISION
Provider Clinical Support

Oregon Health Authority

Documentation for Transplant or Transplant Evaluation Requests

Request instructions

Fax the following documents to 503-378-5814 (for routine processing) or 503-378-3435 (for 1-3 day processing) under an EDMS Coversheet (MSC 3970):

- A completed Prior Authorization Request (MSC 3971) that lists the codes intended for the transplant or transplant evaluation
- A completed copy of this form
- Written statement from specialists and transplant center that support the requested transplant
- Final medical and psychosocial evaluation summary with supporting documentation
- Statement that the patient meets all Division transplant rules and guidelines with no contraindications for the requested transplant
- Statement regarding the specific patient's prognosis and estimated life expectancy with and without transplant

Required information – *Please complete all fields.*

Client name: _____ Medicaid ID: _____

Type of request: ☐ Transplant ☐ Extension ☐ Evaluation Age: _____ Date of birth _____

1) Diagnosis code: _____ CPT code: _____
2) Type of transplant proposed: _____
3) Facility NPI for transplant services: _____
4) Current HIV test results: _____ Test date: _____
5) Further evidence of contraindication for the proposed transplant. See criteria and contraindications for each transplant type in the Transplant Services program rules (410 Division 124). Please indicate if none:

   _____
6) Transplant treatment alternatives:
   a. History of other attempted treatments:

      _____
   b. Treatments considered and ruled out, please include decision why ruled out:

      _____
7) Five-year survival rate with transplant, by percentage: _____ Rate > 20%? ☐ Yes ☐ No

Form completed by: _____ Phone number: _____

Physician's name: _____ Physician's NPI: _____
(please print or type)

Address: _____ Fax number: _____

Physician's Signature – *This section must be signed by the Oregon requesting physician for in-state transplants; or the evaluating/requesting out-of-state physician for out-of-state transplants.*

_____ _____
Signature Date