HUSKY Health Program Organ Transplant
Prior Authorization Request Form
Phone: 1.800.440.5071

THIS FORM IS TO BE COMPLETED BY THE ORDERING PROVIDER AND FAXED WITH CLINICAL DOCUMENTATION TO 203.265.3994

Date of Request: ___________________

Member Information			
Member ID #:		Member Name (Last, First):	
Address:		City, State, Zip:	
DOB:	Sex:	Diagnosis:	ICD 10 Code:

Clinical Information
Type of Transplant:
Procedure Description:
Prognosis (with and without transplant, specifying morbidity, mortality, life expectancy, and any other considerations):
Please attach history of presenting illness to include the following: • Pertinent social history • Clinical findings • Consults • Key test results (representing the patient's current status)
Does the patient meet the transplant selection criteria as outlined by the facility? ☐Yes ☐No Please attach the facility transplant team signed selection criteria notes and/or minutes including discussion of psychosocial concerns, drug or alcohol abuse, patient suitability, quality of life, and compliance.
Does the patient have a contraindication for solid organ transplantation? ☐ Yes ☐ No If yes, please describe:
Is the requested transplant regarded as standard therapy by the medical community? ☐Yes ☐No If no, please attach explanation.
Do urgent or emergent conditions exist? ☐Yes ☐No If yes, please attach explanation.
Note: Review criteria are used as guidelines only. Determinations are based on a person-centered assessment of the individual and their unique clinical needs. Additional information submitted with this request will be considered as part of the medical necessity review process, in accordance with Conn. Gen. Stat. Sec. 17b-259b.

Facility Information		
Medicaid Billing Number:		Billing Provider Name:
Street Address:		City, State, Zip:
Phone #:	Fax #:	Contact Name:

Ordering Provider Information		
Medicaid Billing Number:		Ordering Provider Name:
Street Address:		City, State, Zip:
Phone #:	Fax #:	Contact Name:

Certification Statement: This is to certify that the requested procedure is medically indicated and is reasonable and necessary for the treatment of this patient and that a prescribing practitioner signed order is on file. This form and any statement on my letterhead attached hereto has been completed by me or by my employee and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil and criminal liability.	
Physician Signature:	**Date:**