



NOTICE OF POTENTIAL TRANSPLANT FORM

I N T E R L I N K H E A L T H S E R V I C E S

Source Tracking Number: _____ Date: _____

Contact Information

Name: _____ Phone: _____
Company: _____ Fax: _____
E-Mail: _____

Patient Information

Name: _____ Insured ID: _____
Patient Residence City, State: _____ Date of Birth: _____
Employer Group Name: _____ Sex: Male Female
Employer Group City, State: _____

Benefit Coverage Information

Health Plan Coverage Primary: Yes No Group Renewal Date: _____
Lifetime Maximum Coverage: _____ Organ/Donor Limitations: _____

Transplant Type Information

Type: _____ Organ Source: CD LD
Diagnosis: _____ ICD-9 Code: _____
Candidate Education Booklet: Yes No

Transplant Facility Information

Name: _____ Evaluation Date: _____
City, State: _____

Case Management Information

Case Manager: _____ Phone: _____
Company: _____

Reinsurer Information

Company: _____ Phone: _____
City, State: _____

Claims Payment Information

Company: _____ Phone: _____
Contact: _____ Fax: _____
Street Address: _____
City, State, Zip: _____

Additional Comments

Please fax completed forms to (503) 640-2028.

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