



Heart Transplant Request for Coverage Form

This form should be completed by the person who has a thorough knowledge of the patient's current clinical presentation and his/her treatment history. Please complete all parts as clearly and as specifically as possible. Omissions, generalities, and illegibility will result in the form being returned for completion or clarification.

Please forward this form and clinical documentation requested below to the following address:

- For Tufts Health Plan Commercial, Tufts Health Freedom Plan: 617.972.9409
- Tufts Health Freedom Plan products: Fax: 617.972.9409
- Tufts Health Direct-Health Connector commercial plan; Fax: 888.415.9055
- Tufts Health Together — A MassHealth Plan; Fax: 888.415.9055
- Tufts Health RITogether — A Rhode Island Medicaid Plan; Fax: 857.304.6404
- Tufts Health Unify-OneCare Plan; Fax: 781.393.2607

Demographic Information

Patient Name:		Patient DOB:	
ID #:	PCP or Referring Provider:		
Transplant Physician:	Transplant Facility:		
Evaluation Date:	Listed Date:		
Transplant Coordinator:	Phone #:		
Financial Coordinator:	Phone #:		

Current Diagnosis(es)	ICD Code	Comorbid Diagnoses

CPT Code(s) Requested: _____

Please answer the following questions:

Does the patient have end stage cardiac disease? Yes <input type="checkbox"/> No <input type="checkbox"/>
Does the patient have any serious health conditions that create an inability to tolerate transplant surgery or post-transplant care? Yes <input type="checkbox"/> No <input type="checkbox"/>
Does the patient have any unresolved psychosocial concerns or a history of noncompliance with medical management? Yes <input type="checkbox"/> No <input type="checkbox"/>
Does the patient have a history of malignancy within the past 5 years? Yes <input type="checkbox"/> No <input type="checkbox"/>
Does the patient have any uncontrolled/untreatable infections? Yes <input type="checkbox"/> No <input type="checkbox"/>
Is the patient HIV positive? Yes <input type="checkbox"/> No <input type="checkbox"/>
Does the patient have active or chronic Hepatitis C? Yes <input type="checkbox"/> No <input type="checkbox"/>
Does the patient have systemic illness that will limit survival despite heart transplant? Yes <input type="checkbox"/> No <input type="checkbox"/>
Does the patient have fixed pulmonary hypertension? Yes <input type="checkbox"/> No <input type="checkbox"/>
Has the patient had active alcohol, tobacco, or nicotine delivery system use or substance abuse within the last 6 months? Yes <input type="checkbox"/> No <input type="checkbox"/>

Required Documentation

<input type="checkbox"/> Letter of Medical Necessity, including the following: summary of course of illness, current medications, smoking, alcohol, drug abuse history
<input type="checkbox"/> Medical records, including physical exam, medical history, family history, pulmonary function test, cardiac function studies
<input type="checkbox"/> Laboratory assessment including serologies and CD4 levels
<input type="checkbox"/> Cardiac catheterization with PRV (both before and after medications if PRV>6)

[Provider Services](#)