



## Intestinal and Multivisceral Transplant Request for Coverage Form

Check one: Small Bowel Only  Small Bowel and Liver  Multiple Organs

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 irreversible intestinal failure? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Is the patient HIV positive? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Is the patient TPN dependent? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, how long?	Identify type of complications present
Does the patient have a systemic disease affecting multiple body systems? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please explain: _____	
Does the patient have any unresolved psychosocial concerns or a history of non-compliance with medical management treatment? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Does the patient have any serious health conditions that create the inability to tolerate transplant surgery or post-transplant care? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Does the patient have any uncontrolled/untreatable infections? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Has the patient had active alcohol, tobacco, or nicotine delivery system use or substance abuse in the past 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, and drug abuse history
<input type="checkbox"/> Medical records, including physical exam, medical history and family history
<input type="checkbox"/> Laboratory assessment including serologies and CD4 levels

[Provider Services](#)