



**PAYOR'S NOTICE OF POTENTIAL TRANSPLANT CASE AND REQUEST FOR APPROVAL/CONFIRMATION**

Please complete this form prior to admission and **MAIL** or **FAX** to LifeTrac in Minneapolis **FAX (763) 765-6490**

Send bills to: \_\_\_\_\_  
Company \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
Phone \_\_\_\_\_

**ALLIANZ REINSURANCE CONTRACT #** 7055-593

**DATE:** 06/14/04

**PLAN CONTACT** CARLA FOULKS **PHONE** 612-676-3406 **FAX** 612-884-2000

**PLAN NAME** UCare Minnesota **CITY/STATE/ZIP** Minneapolis, MN 55440-0052

**PLAN ADDRESS** PO Box 52

**Transplant Benefit Limits/Exclusions:** Is the HMO coverage primary?  yes  No

**PATIENT'S NAME**

**DATE OF BIRTH**

**SUBSCRIBERS NAME & SOCIAL SECURITY #**

**TYPE OF TRANSPLANT**

Transplant evaluation date

If solid organ, indicate:  living donor  cadaver

If bone marrow indicate:

- autologous PSC
- autologous BMT
- cord blood
- related allogenic
- unrelated allogenic

**DIAGNOSIS**

**PROPOSED FACILITY** **CITY/STATE**

**USING LIFETRAC NETWORK OR SUPPLEMENTAL CONTRACTED RATE?**  Yes  No

**IF NON-LIFETRAC PROGRAM, GIVE TRANSPLANT COST COMPLENETS QUOTED BY FACILITY:**

Please indicate day #1 as  date of procedure,  one day pre-op,  other

**HOSPITAL RATE:** \$ \_\_\_\_\_ , from day #1 to \_\_\_\_\_ , then per diem \$ \_\_\_\_\_ med/surg ICU

Do per diems include physician fees?  
Add'l amounts?

**PROFESSIONAL FEES:** \$ \_\_\_\_\_ , from day #1 to \_\_\_\_\_ . After day # \_\_\_\_\_ , add'l amounts:

**ORGAN COST:**

**ALL OTHER SERVICES** (pre-op services, post-discharge follow-up, etc.)

**COMMENTS:**

LifeTrac Office Use Only

Thank you. If you need assistance, please call **(763) 765-7800**

Linda Johnson/Susan Adler  
LifeTrac Network/Allianz Life  
1750 Hennepit Avenue  
Minneapolis, MN 55403