RBS Re
An HM Insurance Group Company

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RBS NAVIGATOR PROGRAM
ORGAN TRANSPLANT REFERRAL FORM

NOTE: Please Complete This Form Only When Accessing A Transplant Vendor Network. Use **Notification of Potential Claim Form** *for transplant under Client's Own (Direct) Arrangement*

CHECK APPLICABLE TRANSPLANT NETWORK:

OptumHealth _____ **InterLink** _____ **Lifetrac** _____ **Extra-Contractual** _____

TRANSPLANT MEDICAL CENTER: _____

Contracted Program Type: _____

Diagnosis(es): _____ **ICD-9 code(s):** _____

CLIENT INFORMATION:

Client (Health plan or TPA): _____ **Site (if applicable):** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Client Case Manager: _____ **Phone #:** _____ **Fax #:** _____

CLAIM INFORMATION:

Claim Contact/Representative: _____ **Phone #:** _____ **Fax #:** _____

Claim Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

PATIENT INFORMATION

Name: _____ ☐ **M** ☐ **F** **DOB:** _____ **Phone #:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Patient's SS#: _____ **Policy #:** _____ **Relationship to Primary Insured:** _____

Primary Insured Name: _____ **Primary Insured's SS#:** _____

Patient Coverage Effective Date: _____ **HMO**_____ **POS** _____ **Medicare** _____ **Medicaid**_____

Patient Eligibility Phone #: _____ **Patient Eligibility Fax #:** _____

Patient Eligibility Phone #: _____ **Patient Eligibility Fax #:** _____

Other Coverage: _____ ☐ **Primary** ☐ **Secondary**

ORGAN TRANSPLANT

Has Patient Been Evaluated ? _____ ☐ **Evaluation is not scheduled**

Evaluation scheduled for: _____ **Evaluation rendered on:** _____ **Is Patient on VAD?** _____

Inpatient Dates for Transplant Related Services: **From:** _____ **To:** _____

Give dates for current reinsurance year only. Leave blank if there have been no transplant related admissions. **From:** _____ **To:** _____

Comments/Instructions: _____

Submitted by: _____ **Title:** _____ **Date:** _____

Address: _____ **Tel #:** _____ **Fax #:** _____