



**PREADMISSION CERTIFICATION
TRANSPLANT**
for Wyoming EqualityCare



Note: Certification DOES NOT guarantee payment or client eligibility

Date requested _____
 Admission date _____
 Hospital _____
 Hospital EqualityCare ID # _____
 Hospital UR rep _____
 Phone # _____
 Fax # _____

<p>For APS Healthcare Use Only</p> <p>Date received _____</p> <p>Approved _____ Denied _____</p> <p>Procedure _____</p> <p>Reviewed By _____</p> <p>PCN# _____</p>

Attending/referring physician (first and last name) _____
 Physician Wyoming EqualityCare ID # _____ Phone # _____
 Address _____
You have ONE working day from date of admission to notify APS Healthcare of admission Auth # will be issued.

PATIENT INFORMATION

Name _____ EqualityCare # _____
 Address _____ Phone # _____
 DOB _____ SS# _____ Sex: Male Female
Medical history: Type of transplant _____ Date of disease onset _____

Procedure description and CPT Codes(s): _____

ICD-9-CM code(s) (provide ALL code numbers, as well as diagnosis names):

1. _____ 4. _____
 2. _____ 5. _____
 3. _____ 6. _____

Medical necessity: *Submit information from primary transplant physician including the following:*

- Diagnosis per transplant specialist evaluation
- Clinical indications for procedure
- Medical History including comorbidities
- Prognosis with and without transplants
- Plan of care
- Medical and/or surgical management of diagnosis including alternative therapies
- Statement of patient's ability to adhere to a disciplined medical regimen

Client Name _____ Client EqualityCare ID# _____

Transplant center: Hospital name _____ Phone # _____

Address _____ EqualityCare# _____

Physician Information: List ALL physicians who will be involved in the care of the transplant patient.

• Medical physician name _____ Phone# _____
EqualityCare # _____

• Transplant surgeon name _____ Phone# _____
EqualityCare # _____

• Assistant surgeon name _____ Phone# _____
EqualityCare # _____

• Anesthesiologist name _____ Phone# _____
EqualityCare # _____

• Other physician name _____ Phone# _____
EqualityCare # _____

Other contacts:

• Transplant coordinator _____ Phone# _____

• Transplant nurse _____ Phone# _____

Financial Information:

Financial contact person _____ Phone# _____

Other insurance (including Medicare) precertification obtained? Y / N / Not required

Medicare? Y / N Part A? Y / N Part B? Y / N

EqualityCare is considered the payer of last resort. If no precertification is obtained from EqualityCare and the primary insurance carrier does not reimburse, EqualityCare may deny the claim due to lack of precertification.

Fax form to APS Healthcare toll-free @ 1- 888- 245-1928.

Forms can be found on-line at www.wyoming.apshealthcare.com