



TransplantCARE

Medical Excellence Network by INTERLINK

INTERLINK HEALTH SERVICES

Date: _____

Contact Information

Name: _____
Company: _____
E-Mail: _____

Phone: _____
Fax: _____

Patient Information

Patient Name: _____
Patient Residence City, State: _____
Employer Group Name: _____
Employer Group City, State: _____
Group Renewal Date: _____

Insured ID: _____
Date of Birth: _____
Sex: Male Female

Diagnosis Information

Type: _____
If BMT/PSC Autologous? _____ Allogeneic? _____ / Related? _____
Diagnosis: _____
Candidate Education Booklet: Yes No

Organ Source: CD LD
ICD-9 Code: _____

Transplant Facility Information

Facility Name: _____
City, State: _____

Evaluation Date: _____

Case Management Information

Case Manager: _____
Company: _____
City, State: _____

Phone: _____
Email: _____

Reinsurer Information

Company: _____
City, State: _____
Contact: _____

Phone: _____
Email: _____

Claims Payment Information

Company: _____
Contact: _____
Street Address: _____
City, State, Zip: _____

Phone: _____
Fax: _____
Email: _____

Additional Comments

Please fax completed forms to (503) 640-2028.

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