Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insert Contractor Logo and Address here

AHCCCS Division of Health Care Services

Medical Management Unit

801 East Jefferson St.

Phoenix, Arizona 85034

Fax: (602) 252 - 2180

**Request for Transplant Reinsurance**

Member Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reinsurance Case Number: *From the PMMIS system issued after the case is entered*

AHCCCS ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check box to verify the member does NOT have other insurance coverage:

Not Medicare Eligible:  No Insurance other than AHCCCS:

Diagnosis related to Transplant: *Submit documentation supporting case ONLY if the transplant request is not on the standard diagnosis list from the AMPM*

Type of Transplant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Transplant Center: *Attach copy of the Single Case Agreement or Letter of Agreement if not using an AHCCCS contracted facility*

First Component Start Date: *This date must match the first component date for reinsurance the Contractor will enter in PMMIS after the MMU approves this reinsurance request*

The Health Plan Medical Director has reviewed the request for authorization of this transplant, including the contraindications, and concurs that this transplant meets medical necessity criteria and complies with AHCCCS Medical Policy Manual guidelines (Chapter 300, Section 310-DD). This member meets the criteria for transplant and is found to be appropriate for a referral to a transplant facility for evaluation and subsequent treatment should the member’s evaluation support this further treatment.

The Health Plan will submit any supporting documentation requested by AHCCCS that will aid in the determination of Reinsurance eligibility.

Sincerely,

Medical Director

*Insert Contractor Name*