CIGNA LIFESOURCE TRANSPLANT NETWORK® REFERRAL FORM

Complete this editable Referral Form found at **www.CignaLifeSOURCE.com** under the "Support Services" tab and fax it to **1.877.598.2484**. This form is for use by Health Care Professionals ONLY for referral of a Cigna covered individual for transplantation.

*Indicates a **required** field.

Date: _____

*Name of person making referral: _____

*Call back number: _____

*Patient's name: _____

*Date of birth: _____

*Insured's ID #: _____

*Member's ID #: _____

*Group Account #: _____

*Employer: _____

*Patient's address: _____

_____

*Patient's Phone: (please include all available numbers) _____

_____

*Patient's Email: _____

Doctor information

*Name: _____

*Address: _____

*City: _____ *State: _____ *ZIP code: _____

*Phone: _____

*TIN: _____

This is not a request for medical records; no payment will be made for medical records sent. Submitting this Referral Form does not guarantee services will be certified as medically necessary and/or covered under the applicable health benefit plan. Once the completed form is returned, a transplant case manager should contact you within 24–48 hours.

Thank you

CignaLifeSOURCE.com

Together, all the way.®

Cigna®

Facility information

*Name: _____

*Address: _____

*City: _____ *State: _____ *ZIP code: _____

*Phone: _____

*TIN: _____

*Transplant coordinator: _____

*Phone: _____

*Financial coordinator: _____

*Phone: _____

Transplant information

*Transplant type or VAD: _____

*Diagnosis: _____

*Is the patient currently in the hospital? ☐Yes ☐No

If yes, name of the hospital and city/state: _____

*Does the patient need transplant services (including evaluation) within the next 24 hours? ☐Yes ☐No

If yes, name of the hospital and city/state: _____

*Has patient started evaluation? ☐Yes ☐No

If so, when? _____

Is patient on dialysis? (if applicable) ☐Yes ☐No

If so, when started? _____

If heart transplant, is VAD needed? ☐Yes ☐No

If bone marrow transplant (check applicable) ☐Auto ☐Allo ☐Related ☐Unrelated

If CAR-T Cell Therapy (check applicable) ☐Kymriah ☐Yescarta ☐Breyanzi ☐Abecma ☐Tecartus ☐Carvykti ☐other/clinical trial

If CAR-T Cell Therapy, has leukapheresis (check applicable) ☐Already Occurred? ☐Scheduled?

If Gene Therapy please write in name of the treatment: _____

If lung transplant (check applicable) ☐Single ☐Double

*Other Insurance? ☐Yes ☐No

If so, what company? _____

Who is the primary carrier? _____