

# CIGNA LIFESOURCE TRANSPLANT NETWORK<sup>®</sup> REFERRAL FORM

Complete this editable Referral Form found at [www.CignaLifeSOURCE.com](http://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.<sup>®</sup>**



## 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 Brexanzi 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? \_\_\_\_\_



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