IMMUNOTHERAPY TREATMENT AND TRANSPLANT REFERRAL FORM

Please use this form to submit a referral to AXIS Re A&H Claims. Provide as much information as possible and submit your referral to AXIS Re A&H Claims via: AccidentReClaimsNAM@axiscapital.com

NOTE: INTERLINK®, our preferred vendor, may contact you directly to provide the financial terms of an in-network facility to you within 48 hours of referral receipt. To help us facilitate your referral in a timely manner, please provide all requested information.

HEALTH PLAN INFORMATION

Contact Information

Name*

Company*

Street Address

City, State, Zip

Email*

Phone*

Fax

Benefit Coverage

Health Plan Coverage Primary*

Yes No

Medicare Advantage Plan

Yes No

Medicaid Plan

Yes No

Type of Plan

Fully Insured Self Insured

Carve Out

Yes No

Employer Group Renewal Date

Patient Information

Patient First Name*

Patient Last Name*

Patient Street Address

City, State, Zip*

Employer Group Name*

Employer Group City, State*

Insured ID*

Date of Birth

Sex SELECT BELOW

Transplant Procedure Information

Type SELECT BELOW

If Other or Multi Organ

Age

Adult Pediatric

Organ Source

Cadaveric Donor Living Donor

ICD-10 Code*

Diagnosis*

Evaluation Date

*Required field.

Target Facility Information

Has a facility been identified?*

Yes No

If yes is selected then facility name below is required

Facility

City, State

MGU Information (if applicable)

Company

Street Address

Contact

Phone

Email

Candidate Education Booklet

Send Booklet

(Will be sent to the case manager for distribution to the patient)

Yes No

Additional Comments/Special Instructions

Case Management

Is case management involved?*

Yes No

If yes is selected then Company Name, Contact Name, Phone, and Email below are required fields.

Company

Contact

Street Address

City, State, Zip

Phone

Email

Claims Payment Information

Company

Contact

Street Address

City, State, Zip

Phone

Fax

Email

Submit your referral to
AXIS Re A&H Claims via:
AccidentReClaimsNAM@axiscapital.com

*Required field.