**Tokio Marine HCC – A&H Group**
225 TownPark Drive, Suite 350
Kennesaw, GA 30144 USA
Tel: 800-447-0460

# HCCL Specialty Claims Unit Transplant Referral Form

Submitted by: _____ Date: _____

Group Name: _____ Policy Eff ___/___/_____ Specific Ded: $_____

Laser Ded: $_____ Contract Terms: _____ Split Fund: ☐ Y ☐ N

Transplant Limitations: _____

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**Employee/Claimant Information**

Employee Name: _____ ID#: _____

Claimant Name: _____ ID#: _____

DOB: ___/___/_____ ☐ Male ☐ Female

Effective Date ___/___/_____ ☐ Primary ☐ Secondary

Employee Active ☐ Y ☐ N Other Coverage ☐ Y ☐ N If yes, Carrier: _____

Policy Year (CPTD): _____ Claims Pended: _____

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**Medical/Case Management Information**

Large Case Management Company: _____

CM Contact: _____ PH: (____) ____- _____ext _____ Fax (____) ____- _____

Email: _____

ICD-10 Code: _____ Diagnosis Description: _____ Eval Date ___/___/_____

Facility Name: _____ Transplant Type: _____

Is the Facility in a PPO Network: ☐ Y ☐ N Network Name: _____

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**Claim Information**

Third Party Admin: _____

Txp Contract Contact: _____ PH: (____) ____ - _____ ext ____ Fax (____) ____ - _____

TPA Claims Contact: _____ PH: (____) ____ - _____ ext ____ Fax (____) ____ - _____

Claims Address: _____

Comments: