

Aplos Health Plans Preauthorization Request Form

Submit completed forms and clinical information outlined below by fax to **515-328-6597**, or by secure email to Aplos@innovativecare.com.

"A claim involving urgent care is generally a claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could **seriously jeopardize the life or health of the claimant** or the **ability of the claimant to regain maximum function**; or, in the opinion of the physician with knowledge of the claimant's medical condition, would subject the claimant to **severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.**"

☐ I certify that this request meets the above definition for Urgent processing according to the [Department of Labor](#).

Patient Information

Last Name	First Name	Date of Birth
Employer/Plan Name		Plan ID
Address, City, State, Zip		Phone
Subscriber Name (if different than patient)		Subscriber Relationship

Your Contact Information (Submitted by)

Name	Phone	Fax
Email		

Provider Information

Provider Name	Specialty
Phone	Fax
Provider Primary Address (include suite # if applicable)	NPI
	TIN

Facility Information

Facility	
Phone	Fax
Facility Address (include suite # if applicable)	NPI
	TIN

See next page for service details

Transplant Service Request*	
Date of Service	☐ Not Scheduled
Description of Service(s) Requested	
CPT Code(s)	ICD Code(s)
Is this transplant (or any portion) part of a clinical trial ? ☐ Yes ☐ No ☐ N/A If yes, please submit clinical trial protocol and/or billing guide.	

*For corneal transplants, please use Aplos Health Plan's standard preauthorization request form.

Clinical Information:

For **Transplant Evaluation** send the following:

- ☐ Medical records including **physical exam** and **medical history**
- ☐ Any applicable **diagnostic imaging** and **lab results** (e.g., CT Scan, MRI, Chest Xray, serologies, chemistries, etc.)

For **Transplant Surgery** send the following:

- ☐ *Most recent* medical records including **physical exam** and **medical history** from transplant evaluation
- ☐ **Evaluation of major organ systems** if applicable
- ☐ *Most recent* **laboratory assessment**, including serologies, (e.g., HIV, hepatitis, CMV)
- ☐ *Most recent* applicable **diagnostic imaging** results (e.g., CT scan, MRI, Chest Xray)
- ☐ **Dental evaluation** if available or notation that the program does not require
- ☐ **Psychosocial evaluation**
- ☐ **Age-appropriate cancer screening results** (e.g., colonoscopy, pap smear, mammogram, prostate test)

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