Specialty Claims Unit
Transplant Referral Form

Tokio Marine HCC – A&H Group
225 Town Park Drive, Suite 350
Kennesaw, Georgia 30144
800-447-0460

Stop Loss Carrier (Please check one):

☐ HCC Life Insurance Company ☐ Lasso Healthcare Insurance Company

Submitted by:				Date:	
Group Name:		Policy Effective:		Specific Deductible:	$
Laser Ded:	$	Contract Terms:		Split Fund:	☐ Yes ☐ No
Transplant Limitations:					

Employee/Claimant Information:

Employee Name:				ID #:	
Claimant Name:				ID #:	
Date of Birth:				Gender:	☐ M ☐ F
Effective Date:		Primary or Secondary?		☐ Primary ☐ Secondary	
Employee Active:	☐ Yes ☐ No	Other Coverage:	☐ Yes ☐ No	If yes, Carrier:	
Policy Year (CPTD):		Claims Pended:			

Medical/Case Management Information:

Large Case Management Company:							
CM Contact:		Phone #:		ext.		Fax #:	
Email:							
ICD-10 Code:		Diagnosis Description:				Eval Date:	
Facility Name:				Transplant Type:			
Is the Facility in a PPO Network:	☐ Yes ☐ No			Network Name:			

Claim Information:

Third Party Admin:					
Txp Contract Contact:		Phone #:		Fax #:	
TPA Claims Contact:		Phone #:		Fax #:	
Claims Address:					
Comments:					