**Ohio Medicaid Required Information Form**

This form is only required when Ohio Medicaid is the PRIMARY insurer.

The following information is required by Ohio Medicaid for patients seeking prior authorization for extra renal transplant. All information indicated below is **required**. Ohio Medicaid will not issue a prior authorization without this required information.

This form must be submitted to the OSOTC **as a Word document**. This form is required and must be **uploaded to the online review system** along with the clinical summary at time of review.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Hospital/Billing Provider Information** | | | | | | | | | | | | | | | | | | | | |
| **Hospital Name:** |  | | | | | | | | | | | | | | | | | | | |
| **NPI Number:** |  | | | | | | | | | | | | | | | | | | | |
| **Address:** |  | | | | | | | | | | | | | | | | | | | |
| **Contact Person:** |  | | | | | | | **Contact’s Number:** | | | | | | |  | | | | | |
| **Transplant Information**  *(Beginning and Ending Dates of Services MUST be provided in instances where the surgery date is known)* | | | | | | | | | | | | | | | | | | | | |
| **Organ:** | **ICD 10 Code** | | | **ICD 10 Desciption** | | | | | | | | | | | | | | | | |
|  |  | | |  | | | | | | | | | | | | | | | | |
|  |  | | |  | | | | | | | | | | | | | | | | |
| **Surgery Date**  *(if known)***:** |  | | | **Begin Date**  **of Service:** | | | | |  | | | | | **End Date**  **of Service:** | | | |  | | |
| **Recipient Information** | | | | | | | | | | | | | | | | | | | | |
| **Patient Name:** |  | | | | | | | | | | **Date of Birth:** | | | | | | |  | | |
| **Address:**  *(full residential address)* |  | | | | | | | | | | **Social Security #:** | | | | | | |  | | |
| **Ohio Medicaid Billing #** | |  |  | |  |  |  | | |  | |  |  | | |  |  | |  |  |

***12-digit Medicaid billing number required (11-digit Managed Care number NOT accepted)***

**Procedure Codes & Descriptions Instructions**

1. Procedure code(s) and description(s) must be selected from the table shown on page 2 of this form.
2. Only one “Code & Description” should be selected per organ to be transplanted.
3. When multiple organs are to be transplanted, you may select multiple codes if a combination code does not already exist.
4. Copy your selection from the table on page two of this form and paste it into the “Procedure Codes & Descriptions” area in the table above.

**ICD 10 Procedure Codes & Descriptions**

|  |  |  |
| --- | --- | --- |
| **Organs** | **Code** | **Description** |
| Heart | 02YA0Z0 | Transplantation of Heart, Allogeneic, Open Approach |
| Lung Bilateral | 0BYM0Z0 | Transplantation of Bilateral Lungs, Allogeneic, Open Approach |
| Lung Left | 0BYL0Z0 | Transplantation of Left Lung, Allogeneic, Open Approach |
| Lung Left | 0BYG0Z0 | Transplantation of Left Upper Lung Lobe, Allogeneic, Open Approach |
| Lung Left | 0BYH0Z0 | Transplantation of Lung Lingula, Allogeneic, Open Approach |
| Lung Left | 0BYJ0Z0 | Transplantation of Left Lower Lung Lobe, Allogeneic, Open Approach |
| Lung Right | 0BYK0Z0 | Transplantation of Right Lung, Allogeneic, Open Approach |
| Lung Right | 0BYC0Z0 | Transplantation of Right Upper Lung Lobe, Allogeneic, Open Approach |
| Lung Right | 0BYD0Z0 | Transplantation of Right Middle Lung Lobe, Allogeneic, Open Approach |
| Lung Right | 0BYF0Z0 | Transplantation of Right Lower Lung Lobe, Allogeneic, Open Approach |
| Liver | 0FY00Z0 | Transplantation of Liver, Allogeneic, Open Approach |
| Pancreas | 0FYG0Z0 | Transplantation of Pancreas, Allogeneic, Open Approach |
| Intestine Large | 0DYE0Z0 | Transplantation of Large Intestine, Allogeneic, Open Approach |
| Intestine Small | 0DY80Z0 | Transplantation of Small Intestine, Allogeneic, Open Approach |
| Stomach | 0DY60Z0 | Transplantation of Stomach, Allogeneic, Open Approach |