CHRISTUS Health Plan

# NOTIFICATION FORM

**Dialysis (Initial only) _____ Transplants_____**

**PATIENT INFORMATION** **Fax back to: 844-357-7562**

| | | |
|---|---|---|
| Name: | Phone: | DOB: |
| Member ID#: | Group #: | Gender: |

**PROVIDER INFORMATION**

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|---|
| Service Provider or Facility:<br><br>Name:<br><br>NPI#<br><br>Phone #:<br><br>Fax #: |
| Transplant Provider or Facility:<br><br>Name:<br><br>NPI#<br><br>Contact Name:<br><br>Phone #: Fax #: |

**SERVICES REQUESTED (WITH CPT CODE) AND SUPPORTING DIAGNOSES (WITH ICD CODE)**

| Planned Service or Procedure | Code | Start Date | End Date | Diagnosis Description (ICD version___) | Code |
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**Please attach any supporting documentation and additional service codes needed.**

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