****

**Transplant Team Referral Form**

Name of Form Submitter:

Date of Submission:

Phone number of Submitter:

Include the following with Transplant Team Referral Form submission:

1. Copy of approved authorization
2. Clinical documentation submitted with authorization request

**Fax this Transplant Team Referral Form, approved authorization, and clinical documentation to the**

**IEHP Transplant Team at 909-477-8542**.

For inquiries, please contact the IEHP Provider Relations Team at (866) 725-4347. Thank you.

This facsimile message is intended only for the use of the individual or entity named above and may contain information, which is confidential, non-public or legally privileged. Any dissemination or distribution of this message other than to its intended recipient is strictly prohibited. If you have received this message in error, please notify IEHP immediately and return the original message and all copies to IEHP at the address noted on the fax by mail.