Attachment A

Required Information for all Applications for Medicare Approval of Transplant Programs

TRANSPLANT HOPSPITAL INFORMATION

1. Name of Transplant Hospital _____
2. Address of Transplant Hospital _____
3. Type(s) of Transplant Programs for which Medicare Approval is Requested _____
4. Address of Transplant Program (if different from transplant hospital) _____
5. National Provider Number (NPI) for Transplant Hospital _____
6. CMS Certification number for the Transplant Hospital in which the Transplant Program is Located _____
7. Organ Procurement Transplant Network (OPTN) Membership Identifier _____
8. Email Address _____

TRANSPLANT PROGRAM DIRECTOR INFORMATION

9. Program Director's Name _____
   a) Phone Number _____
   b) Email address _____
   c) Fax Number _____

PRIMARY TRANSPLANT PHYSICIAN DESIGNATIONS to the OPTN

10. Name of Primary Transplant Surgeon Designated to the OPTN (for each approval request) _____
11. Name of Primary Transplant Physician Designated to the OPTN (for each approval request) _____

VOLUME REQUIREMENTS

12. List the Volume (number of transplants performed) within the last year to meet the Transplant CoP Volume Requirements for Initial. See 42 CFR 4892.80(b) _____

For Pediatric Heart Transplant Program Requests under 42.CFR 482.76(d)

13. If you are requesting approval for a pediatric heart transplant program under the alternative approval criteria (42 CFR 482.76(d))please include:

    a) National Provider Number (NPI) of the Other Facility _____

    b) Name of Shared Transplant Surgeon _____

_____ _____

Signature of Authorized Representative of Transplant Hospital Date