Continuity of Care Review for Members of Tiered or Limited Network Plans: Massachusetts Request Form

This form should be completed to inform Tufts Health Plan of your patient's need to continue to access care under the Continuity of Care regulations (211 CMR 153.00). Please send the completed form and any supporting documentation to: FAX 617.972.9409 or by mail to Tufts Health Plan, 705 Mount Auburn Street/Watertown, MA 02472-1508.

Please complete the following member Information:

Member Name:	Member DOB:	Date of Request:
Member ID#:	Diagnoses (ICD):	

At which facility is your patient receiving care:

☐ Dana Farber Cancer Institute ☐ Children's Hospital Boston ☐ Shriners Hospitals for Children - Boston ☐ Shriners Hospitals for Children - Springfield ☐ Floating Hospital for Children at Tufts Medical Center ☐ Nashoba Valley Medical Center (pediatric only) ☐ Massachusetts Eye and Ear Infirmary (pediatric only)
Facility Address:
Date of first appointment for the treatment of this diagnosis:
Date of the most recent appointment for the treatment of this diagnosis:
Date of the next appointment for the treatment of this diagnosis:

Reason for continuing care at the current facility:

Please explain why this member needs to continue receiving care at the facility checked above. Please include answers to the following questions in your response: Is this care available at a non-specialty facility? ☐ Yes ☐ No What would be the impact of moving the member's treatment to another facility and/or provider?
What is the member's current treatment plan?

Please complete the following physician/provider information:

Provider Name:	Provider NPI #:
Provider Specialty:	
Provider Phone #:	Provider Fax #:
Provider Address:	
Provider Signature:	

Provider Services