TUFTS Health Plan

Out-of-Network Outpatient Dialysis at the In-Network Level of Benefits Prior Authorization Form

Please fax the completed form to the plan listed below:

- Tufts Health Plan Commercial Plans; fax: 617.972.9409
- Tufts Health Freedom Plan products; fax: 617.972.9409

1. Member name:	2. Member DOB:	3. Member ID#:
4. Requesting provider name:	5. Requesting provider ID/NPI#:	6. Requesting provider **fax#:**
		7. Requesting provider **phone #:**
8. Outpatient dialysis provider name:	9. Outpatient dialysis provider NPI#:	10. Outpatient dialysis provider **fax#:**
		11. Outpatient dialysis provider **phone #:**
12. Outpatient dialysis facility name:	13. Outpatient dialysis facility NPI#:	14. Outpatient dialysis facility **fax#:**
		15. Outpatient dialysis facility **phone #:**

16. Dialysis service(s) requested:	17. CPT/HCPCS code(s) of requested dialysis service(s):

☐ Outpatient dialysis services are not available within Tufts Health Plan's geographic access standard, which is 30 miles from the Member's primary residence

Choose one:

☐ In-network outpatient dialysis facilities **are not located** within 30 miles from the Member's primary residence

☐ In-network outpatient dialysis facilities located within 30 miles from the Member's primary residence **are not currently available** for Member to receive services. Please explain:

_____

_____

_____

☐ Outpatient dialysis services received in the Member's primary residence are not available from an in-network provider.

18. Number of months requested (up to 12 months):

Signature of requesting provider: _____ Date of request: _____

Provider Services