Out-of-Network Coverage at In-Network Level of Benefits Prior Authorization Form

Please use this form to request prior authorization when Tufts Health Plan is responsible for determining whether it is medically necessary for the Member to receive services from an out-of- network provider.

Please fax the completed form to the Member's plan listed below:

For MEDICAL services requests, use this table to identify the correct fax number:

Tufts Health Commercial Plans	*Member ID begins with a number	Fax: 617.972.9409
Tufts Health Freedom Plans	*Member ID begins with a number	Fax: 617.972.9409
Tufts Health Public Plans		
Tufts Health Direct	*Member ID begins with "**N**"	Fax: 888.415.9055
Tufts Health Together **Tufts Health RITogether**	*Member ID begins with "**N**" *Member ID begins with "**R**"	Fax: 888.415.9055 Fax: 857.304.6404
Tufts Health Unify-OneCare Plan	*Member ID begins with "**N**"	Fax: 857.304.6304

For BEHAVIORAL HEALTH services requests, use this table to identify the correct fax number:

Tufts Health Commercial Plans	*Member ID begins with a number	Fax: 617.972.9424
Tufts Health Freedom Plans	*Member ID begins with a number	Fax: 617.972.9424
Tufts Health Public Plans		
Tufts Health Direct	*Member ID begins with "**N**"	Fax: 888.977.0776
Tufts Health Together **Tufts Health RITogether**	*Member ID begins with "**N**" *Member ID begins with "**R**"	Fax: 888.977.0776 Fax: 857.304.6404
Tufts Health Unify-OneCare Plan	*Member ID begins with "**N**"	Fax: 857.304.6304

Member and Provider Information-*Please complete all applicable fields on both pages and submit any supporting clinical documentation*

1. Member name:	Member DOB:	Member ID#:
2. **Requesting** provider name:	Requesting provider ID/NPI#:	Requesting provider **fax#:** Requesting provider **phone #:**
3. **Out-of-network** provider name:	Out-of-network provider NPI#:	Out-of-network provider **fax #**: Out-of-network provider **phone#:**
Out-of-network provider address:	City:	State: ZIP code:
Out-of-network provider Tax ID:	Out-of-network provider license number:	

Out-of-Network Service Requested (e.g. office visit, therapy/treatment):____________________________ CPT Code(s) for Service Requested: __________________	Date of Request:
Member requests out of network care and/or there is no clinical indication that meets options below: ☐	**Medical/Surgical:** ☐ **Behavioral Health:** ☐

The clinical expertise to address the specific health care needs of the Member is not available from any in-network provider:

Choose all that apply:

☐ The Member has a **rare medical condition** or need for a **specialized procedure** for which there is **no in-network provider with the expertise** to provide treatment or perform procedure. **Please explain:**

____
____
____

☐ The Member's primary language is one that the in-network treating provider does not speak and it is that provider's opinion that the Member's treatment is likely to be **compromised due to language barrier and insufficiency of translation services**. **Please explain**:

____
____
____

☐ The Member is a resident in a nursing home or inpatient in a SNF and cannot travel and in-network providers are not available to treat the Member in that setting. **Please explain:**

____
____
____

☐ In-network provider with the clinical expertise needed to treat the Member **is not reasonably available** within Tufts Health Plan's geographic access standard **(30 miles from Member's primary residence)** or within the availability standards of the Member's plan. **Please explain:**

____
____
____

☐ The Member was treated by an out-of-plan specialist in an emergency department **and** required an inpatient admission as a result of the emergency department treatment and follow up with that out-of-plan specialist is required. **Please explain:**

____
____
____

Number of follow-up visits (limit 2) :_______________

Additional clinical information for above scenarios:

☐ Prior to enrolling in Tufts Health Plan, the Member initiated **outpatient psychotherapy** treatment with a licensed out of plan provider and that provider attests that failure to continue treatment is highly likely to lead to significant harm to the Member.

Start of treatment for current episode of care: Beginning date: ____________________to __________________________

Diagnoses (DSM-5 number and narrative):

____

____

____

Reason for requesting out of plan care at this time:

____

____

____

____

____

____

____

Is the patient at **current risk of hospitalization**? If yes, please explain.

____

____

____

Is the patient at **current risk for assaultiveness or harm to self**? If yes, please explain.

____

____

____

List other Behavioral Health professionals currently treating the Member:
Name/Treatment Modality/Frequency

____

____

____

Current medications (including dosage and frequency) and name of prescribing physician:

____

____

____

Goal Oriented Treatment Plan:
Primary
Problem:____

____

____

Goal ____

____

Interventions (Proposed interventions with frequency and duration):

____

____

____

____

____

Additional information related to above out of plan outpatient psychotherapy request:

Provider Signature: