Recovery Support Navigator Services Notification Form for In-Network Providers Only

Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans (ACPPs): Fax to 888.977.0776
Tufts Health Unify: Fax to 857.304.6304
Tufts Health Plan Senior Care Options (SCO): Fax to 617.972.9424

Today's date: ___/___/___ Initial date of service ___/___/___

Notification required within one week of the start of services. Notification allows the provider to use and bill up to 90 days/360 units from the date services are initiated. ***Requests for further continued stay authorizations are to be requested telephonically by calling 888.257.1985.***

MEMBER INFORMATION

Name: _____ Tufts Health Plan Member ID: _____
Address: _____ Phone: ____ / ____/- _____
City:_____ DOB: ____/____/_____
State: _____ ZIP: _____

PROVIDER INFORMATION

Organization name: _____ Organization phone #: _____
NPI _____ Tax ID _____
Provider address: _____
City: _____
State: _____ ZIP: _____
Recovery navigator name: _____ Supervisor name: _____
Recovery navigator phone: _____ Supervisor phone:_____
Referred by (name) _____, who is a: Medical Provider Behavioral Health Provider Community Partner (CP) Care Manager Other _____
Fax number to fax authorization letter: ___/____/ ____

CLINICAL INFORMATION

1. List ICD-10 Alpha Numeric Diagnosis Code: _____

2. Attach a copy of the document that outlines the set of goals and objectives.

3. Choose all that apply:

Admission Criteria

The Member is at a transition point in treatment and/or recovery and/or at risk for admission to 24 hour behavioral health inpatient/diversionary services, as evidenced by one or more of the following:

☐ Discharge from a 24-hour behavioral health inpatient/diversionary level of care within the past 180 days
☐ Multiple ESP and/or emergency department (ED) encounters within the past 90 days
☐ Documented barriers to accessing and/or consistently utilizing essential medical and behavioral health services

☐ Initiating or changing an addiction pharmacotherapy or medication assisted treatment (MAT) regimen and/or changing MAT provider
☐ Release from incarceration within 90 days
☐ Loss of housing stability within 90 days
☐ Loss of employment within 90 days
☐ Loss of family support and connection within 90 days
OR
☐ The member is referred by a primary care provider for assistance with necessary medical follow-up

Exclusion Criteria
Member:
☐ is at acute risk to harm self or others, or sufficient impairment exists to require a more intensive level of service beyond community-based intervention;
☐ has severe medical conditions or impairments that would prevent beneficial utilization of services;
☐ is receiving similar supportive services and does not require this level of care;
☐ the member's parent/guardian/caregiver when applicable, does not consent to Recovery Support Navigator services.

ATTESTATION

I attest that we are meeting the performance specifications for this level of care.

Signature: _____

Print Name: _____ Date: _____