Recovery Coach Services Notification Form for In-Network Providers Only

Tufts Health Together - 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 6 months from the date services are initiated.

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 coach name: __________________________ Supervisor name: ____________________
Recovery coach 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 <u>Alpha Numeric</u> Diagnosis Code: ______________

2. Attach a copy of the member's Wellness Plan, developed in initial meeting.

3. Choose all that apply:

<u>Admission Criteria</u>

Member:

- ☐ is attempting to gain any amount of sobriety
- ☐ could benefit from education about harm reduction and/or education about recovery and community resources
- ☐ could benefit from support in increasing motivation and readiness to change
- ☐ could benefit from peer support in establishing connections with the recovery community
- ☐ could benefit from the structure of a Wellness Plan

Exclusion Criteria
Member:
☐ is at acute risk to harm self or others, or sufficient impairment exists to require 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;
☐ Member or parent/guardian/caregiver when applicable, does not consent to Recovery Coach Services.

ATTESTATION

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

Signature: ____

Print Name: ____ Date: ___________________