TUFTS Health Plan

Personal Assistance Services and Supports (PASS) Prior Authorization Request Form – Tufts Health RITogether

Fax the completed form to 857.304.6404
Today's date: ____/____/____
Date range of services requested: ____/____/____ to ____/____/____
PASS services require prior approvals for:

- ☐ Request for initial assessment for service planning
- ☐ Request for direct services
- ☐ Request for clinical consultation

A qualified PASS agency is responsible, along with a qualified health professional, for all assessment and service plan development.

MEMBER INFORMATION

Name: ___________________________ DOB: _____________________

ID #: ____________________________

Address: _________________________

City: _____________________________ State: ____________________ ZIP: _________

PROVIDER INFORMATION

Name: __________________________________ NPI #: _____________________

Address: _______________________________

City: _____________________________ State: ____________________ ZIP: ___________

Tax ID #: ________________________ Phone: ____________________Fax: ___________

Licensure: ____

How many times have you seen this patient? _______________________________________

Date of most recent contact: ____/____/____

Requested Services
The submission of this form does not guarantee authorization of your request. If your patient is younger than 18 years of age, a parent or legal guardian must be present at all treatment visits.

Has the parent or legal guardian committed to being present at all treatment visits? ☐ Yes ☐ No

Use the following codes when representing prior authorization for continued services. **Note: For Tufts Health RITogether patients, use modifier U2.*

Code	Description	# of Units Requested
T1019 TF	Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant).	
T1019 TG	Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant.), (select reimbursement code based on direct service worker's level of education and experience)	

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T1023	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter	
T1023 UI	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter	
T1027	Family training and counseling for child development, per 15 minutes	
T1040	Medicaid certified community behavioral health service team, per diem	
T1041	Medicaid certified community behavioral health service team, per month	
G0151	Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes	
G0152	Services performed by a qualified occupational therapist in the home health or hospice setting each 15 minutes	
G0153	Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes	
G0159	Services performed by a qualified physical therapist, in the home health setting in the establishment or delivery of a safe and effective physical therapy maintenance program, each 15 minutes	
G0160	Services performed by a qualified occupational therapist, in the home health setting in the establishment or delivery of a safe and effective occupational therapy maintenance program, each 15 minutes	
G0161	Services performed by a qualified speech-language pathologist, in the home health setting in the establishment or delivery of a safe and effective speech-language pathology maintenance program, each 15 minutes	
G0177	Training and educational services related to the care and treatment of a patient's disabling mental health problems per session (45 minutes or more)	
H2014	Skills and training development, per 15 minutes	
H2016	Comprehensive community support services, per diem	
H2016 UI	Comprehensive community support services, per diem (direct coordination)	
H2021	Community-based wrap-around services, per 15 minutes	
H2022	Community-based wrap-around services, per diem	
H2037	Developmental delay prevention activities, dependent child of client, per 15 mins	
H0036	Community psychiatric supportive treatment, face-to-face, per 15 minutes	
H0037	Community psychiatric supportive treatment program, per diem	
H0039	Assertive community treatment, face-to-face, per 15 minutes	
H0040	Assertive community treatment program, per diem	
H2015	Comprehensive community support services, per 15 minutes	

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H2016	Comprehensive community support services, per diem	

With submission of this form, attach a summary of information to answer the following questions:

1. What is the member's individual service plan?

   ____
   ____
   ____
   ____

2. How will you accomplish goals?

   ____
   ____
   ____

3. What are functional impairments?

   ____
   ____
   ____

4. Who referred you to PASS services?

   ____
   ____
   ____

5. Who is involved with the member's treatment?

   ____
   ____
   ____