TUFTS Health Plan

Residential Rehabilitation Services (RRS) Admission 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

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

Notification required within one week of the start of services. Upon timely notification, initial authorization for 90 days will be entered from the date of admission, enabling provider to bill for the services.

Level of RRS: (Select one)
☐ Adult ☐ Family ☐ Transitional ☐ Youth ☐ Pregnant/Post-Partum ☐ Co-occurring/enhanced

MEMBER INFORMATION

Member name: _____ Tufts Health Plan Member ID: _____
Member address: _____ Member phone: ____ / ____/- _____
City: _____ Member DOB: ____/____/_____
State: _____ ZIP:_____

PROVIDER INFORMATION

Provider organization name: _____ Organization phone: _____
NPI _____ Tax ID _____
Provider address: _____
Provider City/State/Zip: _____
Clinical contact name: _____ Supervisor name: _____
Clinical contact phone: _____ Supervisor phone:_____
Fax to send authorization to: ____/____/____

CLINICAL INFORMATION (DIAGNOSIS INFORMATION IS NECESSARY TO BILL FOR INITIAL TREATMENT PERIOD OF 90 DAYS)

1. ICD-10 Alpha Numeric Diagnosis Code from Prior Level of Care: _____
Current ICD-10 Alpha Numeric Diagnosis Code: _____
Additional Alpha Numeric Diagnosis Code: _____
Additional Alpha Numeric Diagnosis Code: _____
Additional Alpha Numeric Diagnosis Code: _____

THE INFORMATION SHOWN BELOW IS REQUESTED BUT NOT REQUIRED FOR NOTIFICATION

2. Is member involved with state agencies? (Select all that apply) ☐ None ☐ DMH ☐ DCF ☐ DDS ☐ DYS ☐ Other

_____

3. How was the member referred?

_____
_____

4. Prior level of care for the member

_____
_____

5. Please attach the assessment tools including the biopsychosocial clinical assessment

6. Please attach the After Care Plan

7. Is the member receiving medication assisted treatment (MAT)? ☐ Yes ☐ No

8. If yes, where is the treatment being administered?

_____

ATTESTATION

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

Signature: _____

Print Name: _____ Date: ____/____/_____