Tufts Medicare Preferred HMO Denial of Coverage and Expedited Approval Form Instructions

Enter the member's name and member identification number.

SECTION A

1. Select the most appropriate check box option to indicate the type of service/supply being requested. If DME or Other is checked, enter the specific request (e.g., 2000 suction catheters, full electric hospital bed).
2. Enter the reason for requesting the service/supply (e.g., member has a tracheotomy and needs to be suctioned 5 times a day)

SECTION B

1. Check the appropriate box to indicate if the request is for services that are still ongoing (concurrent) for services that have not yet occurred (pre-service).
2. Indicate requestor's relationship to the member.
3. Enter the name of the person requesting the service, if other than the member. If services were not requested by the member or an MD, a signed Appointment of Representation (AOR) or Power of Attorney will be required.

SECTION C

1. Enter the date and time the initial request was received.
2. Check the appropriate box to indicate how the request for the service/supply was received.
3. Check the appropriate box to indicate if the requestor requested an expedited or fast decision.
4. Check the appropriate box to indicate the requestor's reason for requesting an expedited or fast decision.
5. Check the appropriate box to indicate if the physician agrees with the request for an expedited decision. If the physician does not agree, explain why.
6. Check the appropriate box to indicate if the medical group expedited the request. If the group did not expedite the request, explain why.
7. If Yes is checked for item C.3, check the appropriate box to indicate if the request was approved or denied. For both approvals and denials, fax the form to the Tufts Health Plan Precertification Department within 24 hours of the request, even if the group did not expedite the decision. Tufts Health Plan must track all expedited requests, both approval and denials.

Note: If a request for an expedited organization determination does not meet expedited criteria, the member/member representative must be informed both verbally and in writing within 72 hours of receipt of the request that the request will follow the standard time frame and that the requestor has the ability to file a grievance regarding this decision. Medical groups are required to inform the requestor verbally and fax the form to Tufts Health Plan Precertification Department within 24 hours of the request so that the requestor can be informed in writing of the decision not to expedite and be informed of their expedited grievances rights. Requests for expedited organization determinations must be honored if the expedited request is either made or supported by a physician, or if waiting for a standard organization determination might jeopardize the member's health, life or ability to regain maximum

SECTION D

1. Indicate the reason for the denial by checking the appropriate box. For boxes d-h, enter the required information (e.g., providers to whom member could be referred; for 100-day exhaustion, list Skilled Nursing Facilities with admission and discharge dates and where member went at time of discharge). **Incomplete forms will be returned for additional information.**
2. For boxes 1 a-c, indicate specific section of EOC or Medicare Coverage Criteria on which decision is based.
3. State the reason for the denial as documented in progress notes or attach a copy of the progress note that supports the decision.
4. Form must be signed by the physician making the denial recommendation at the time of the recommendation. The physician's signature is attestation that his/her professional review of the case and all documentation supports the decision. Enter the name, phone number and fax number of the office contact, and the date and time the physician made the denial recommendation.

From the time the initial request is received, regardless of whether a decision has been made, you must fax the form to Tufts Health Plan Precertification Department at 617.673.0955 within 5 days for a standard review or 24 hours for an expedited review. Provider Relations