Out-of-Network Coverage at In-Network Level of Benefits and Continuity of Care Prior Authorization Form

Point32Health

Harvard Pilgrim Health Care | TUFTS Health Plan

Please use this form to request prior authorization when the plan is responsible for determining whether it is medically necessary for the Member to receive services from an out-of-network provider. **All fields are required.** Please fax the completed form to the Member's plan listed below:

For MEDICAL services requests *(use this table to identify the correct fax number)*

Harvard Pilgrim Health Plan Commercial products

Harvard Pilgrim Health Plan Commercial	Fax: 800-232-0816

Tufts Health Commercial Plans products

Tufts Health Commercial Plans	Fax: 617-972-9409

Tufts Health Public Plans products

Tufts Health Direct	Fax: 888-415-9055
Tufts Health Together	Fax: 888-415-9055
Tufts Health RITogether	Fax: 857-304-6404
Tufts Health One Care	Fax: 857-304-6304

Tufts Health Senior Products

Tufts Health Medicare Preferred	Fax: 617-972-9409
Tufts Health Senior Care Options	Fax: 617-673-0930

Harvard Pilgrim Health Care Stride Medicare Advantage Plan

Harvard Pilgrim Stride Medicare Advantage	Fax: 866-874-0857

For BEHAVIORAL HEALTH service requests *(use this table to identify the correct fax number)*

Harvard Pilgrim Health Plan Commercial products

Harvard Pilgrim Health Plan Commercial	Fax: 800-232-0816

Tufts Health Commercial Plans products

Tufts Health Commercial Plans	Fax: 617-972-9409

Tufts Health Public Plans products

Tufts Health Direct	Fax: 888-977-0776
Tufts Health Together	Fax: 888-977-0776
Tufts Health RITogether	Fax: 857-304-6404
Tufts Health One Care	Fax: 857-304-6304

Tufts Health Senior Products

Tufts Health Medicare Preferred	Fax: 617-972-9409
Tufts Health Senior Care Options	Fax: 617-673-0930

Harvard Pilgrim Health Care Stride Medicare Advantage Plan

Harvard Pilgrim Stride Medicare Advantage	Fax (Optum UBH): 844-512-9824

Member and Provider Information

Please complete all fields on all pages and submit any supporting clinical documentation

1. Please check the appropriate box (*required information*):

Patient is new to the Plan Patient's provider/facility is no longer in network

Other:

2. Member name:

Member ID # Date of birth (*mm/dd/yyyy*):

3. Requesting provider name:

Requesting provider address (*street, city, state, ZIP*):

Requesting provider ID/NPI # Fax: Phone:

4. Out-of-network provider name:

Out-of-network provider NPI # Fax: Phone:

Out-of-network provider address (*street, city, state, ZIP*):

Out-of-network provider Tax ID #

Out-of-network provider license number:

Date of request (*mm/dd/yyyy*):

Service requested (*e.g., office visit, therapy/treatment*):

CPT code(s) for service requested:

DSM 5 Diagnoses/ICD 10 code:

Medical/Surgical **Behavioral Health**

General Out-of-Network Coverage at the In-Network Level of Benefits (*for all Point32Health lines of business*):

The clinical expertise to address the specific health care needs of the Member is not available from any in-network provider.
Choose all that apply:

The Member has a **rare medical condition** and there is no in-network provider with the necessary specialization, training, or expertise to provide treatment. **Please explain:**

The Member requires a **specialized medical procedure** for which there is no in-network provider with the necessary specialization, training, or expertise to perform the procedure. **Please explain:**

The Member's **primary language** is one that the treating in-network provider does not speak, and no in-network provider speaks, and it is the treating provider's opinion that treatment is highly likely to be compromised due to the language barrier and the insufficiency of translation services available in the service area. **Please explain:**

The Member is a **resident in a nursing home, or inpatient in a skilled nursing facility** and cannot travel and in-network providers are not available to treat the Member in that setting. **Please explain:**

In-network providers with the clinical expertise required to address the Member's diagnosis or medical condition are **not reasonably available within the Plan's geographic access standards (30 miles from Member's primary residence)** or within the availability standards of the Member's plan. **Please explain:**

The Member was treated by an out-of-plan specialist provider in an **emergency department** and including an inpatient admission as a direct result of that emergency department treatment will be permitted up to 2 follow-up visits with the treating out-of-network specialist provider. **Please explain:**

Number of follow-up visits (limit 2): Additional clinical information for above scenarios:
The Member requires **outpatient psychotherapy** treatment with a licensed out of plan provider. **Please explain:**

Continuity of Care Requests (*Prior authorization is <u>not</u> required for Tufts Health Together and Dual Eligible Plans*):

Please include diagnosis, expected treatment duration and dates of surgery if scheduled.

The Member is **pregnant.** Please document due date:

The Member is considered **terminally ill** (life-expectancy < 6 months). **Please explain:**

The Member is undergoing active treatment for an **acute condition or a non-routine condition (medical or behavioral health). Please explain:**

Other. Please describe reason for requesting continuity of care: