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

Prior Authorization Request 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.** Submit the **completed** form and required documentation for review. We encourage you to complete and submit your request using our secure portals. For details on this and other options, please refer to our How to request prior authorization webpage.

Member and provider information

Please check the appropriate box: ☐ Patient is new to the Plan ☐ Patient's provider/facility is no longer in network

Other:

Member name: Date of birth: / /

Member ID#

Requesting provider name: NPI #

Requesting provider address:

Phone: Fax:

Out-of-network provider name: NPI #

Out-of-network provider address:

Phone: Fax:

Out-of-network provider Tax ID #

Out-of-network provider license #

Date of request: / /

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:**

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Prior Authorization Request Form (cont.)

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- [ ] 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 during an emergency department visit or an inpatient admission and is **permitted to up to 2 follow-up visits** with the treating out-of-network specialist. **Please explain:**

- [ ] The Member requires **outpatient psychotherapy treatment** with a licensed out of plan provider. **Please explain:**

Continuity of Care Requests (*Prior authorization is not 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:

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