Recovery Support Navigator Services Notification Form for In-Network Providers Only

TUFTS Health Plan
a Point32Health company

Rev. 7/2026

Completed forms can be faxed to the following locations:

- **Tufts Health Together:** 888-977-0776
- **Tufts Health One Care:** 857-304-6304

Today's date / / Initial date of service / /

Notification required within one week of the start of services. Notification allows the provider to use and bill up to 90 days/360 units from the date services are initiated. **Requests for continued stay authorizations are to be requested by phone at 888-257-1985.**

Member Information

Member name

THP member ID # DOB / /

Member address Member phone

City State ZIP

Provider Information

Organization name Organization phone

NPI # Tax ID #

Provider address

City State ZIP

Recovery Navigator name Recovery Navigator phone

Supervisor name Supervisor phone

Referred by (name) , who is a:

☐ Medical Provider ☐ Behavioral Health Provider ☐ Care Manager

☐ Other (*Please specify*)

Fax to send authorization to

Clinical Information

1. ICD-10 Alpha Numeric Diagnosis Code

2. Attach a copy of the documents the set of goals and objectives.

3. *Choose all that apply*:

Admission Criteria

The Member is at a transition point in treatment and/or recovery and/or at risk for admission to 24 hour behavioral health inpatient/ diversionary services, as evidenced by one or more of the following:

☐ Discharge from a 24-hour behavioral health inpatient/diversionary level of care within the past 180 days
☐ Multiple ESP and/or emergency department (ED) encounters within the past 90 days
☐ Documented barriers to accessing and/or consistently utilizing essential medical and behavioral health services
☐ Initiating or changing an addiction pharmacotherapy or medication assisted treatment (MAT) regimen and/or changing MAT provider
☐ Release from incarceration within 90 days
☐ Loss of housing stability within 90 days
☐ Loss of employment within 90 days
☐ Loss of family support and connection within 90 days

OR

☐ The member is referred by a primary care provider for assistance with necessary medical follow-up

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Exclusion Criteria

Member:

- ☐ is at acute risk to harm self or others, or sufficient impairment exists to require a more intensive level of service beyond community-based intervention;
- ☐ has severe medical conditions or impairments that would prevent beneficial utilization of services;
- ☐ is receiving similar supportive services and does not require this level of care;
- ☐ or parent/guardian/caregiver when applicable, does not consent to Recovery Support Navigator Services

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Attestation

I attest that we are meeting the performance specifications for this level of care as described by the performance specification in the Recovery Support Navigator Performance Specifications.

Signature _____ Print name _____ Date ____ / ____ / _____

CLEAR FORM