Personal Assistance Services and Supports (PASS) Prior Authorization Request Form – Tufts Health RITogether

For Tufts Health RITogether, fax to 857.304.6404

Today's date: ____/____/____

Date range of services requested: ____/____/____ to ____/____/____

PASS services require prior authorization approvals for:

- ☐ Request for initial assessment for service planning
- ☐ Request for direct services
- ☐ Request for clinical consultation

A qualified PASS agency is responsible, along with a qualified health professional, for all assessment and service plan development.

MEMBER INFORMATION

Name: _____ ID #: _____ DOB: ___/___/_____

Address: _____ Phone: _____

City: _____ State: _____ ZIP: _____

PROVIDER INFORMATION

Name: _____ NPI #: _____

Address: _____

City: _____ State: _____ ZIP: _____

Licensure: _____

Tax ID #: _____ Fax: _____

Name and phone number of the person to contact with questions:

_____

How many times have you seen this patient? _____ Date of most recent contact: __/__/_____

REQUESTED SERVICES

The submission of this form does not guarantee authorization of your request. If your patient is younger than 18 years of age, a parent or legal guardian must be present at all treatment visits.

Has the parent or legal guardian committed to being present at all treatment visits? ☐ Yes ☐ No

**Use the following codes when representing prior authorization for continued services.*

Code	Description	# of Units Requested
T1016	Case Management	
T1019	Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant).	
T1023	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter	

Code	Description	# of Units Requested
T1027	Family training and counseling for child development, per 15 minutes	
H2016	Comprehensive community support services, per diem	

With submission of this form, attach a summary of information to answer the following questions:

1. What is the member's individual service plan?

   _____
   _____
   _____
   _____

2. How will you accomplish goals?

   _____
   _____
   _____

3. What are functional impairments?

   _____
   _____
   _____

4. Who referred you to PASS services?

   _____
   _____
   _____

5. Who is involved with the member's treatment?

   _____
   _____
   _____