Prior Authorization Request Form

Point32Health

Harvard Pilgrim Health Care | TUFTS Health Plan

Tufts Health RITogether

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.

Today's date: / /

Service type requiring authorization (*check all that apply*)

Ambulatory/Outpatient services
- Surgery/Procedure (SDC)
- Infusion or Oncology drugs

Ancillary
- Acupuncture
- Chiropractic
- IVF/ART
- Non-participating specialist

Dental
- Adjunctive dental services
- Endodontics
- Maxillofacial prosthetics
- Oral surgery
- Restorative

Durable medical equipment (DME)
- Prosthetic device
- Purchase
- Renal supplies
- Rental

Home health/Hospice
- Home Health:
  - SN
  - PT
  - OT
  - ST
  - HHA
  - MSW
- Hospice
- Infusion therapy
- Respite care

Inpatient care/ Observation
- Acute medical/surgical
- Long-term acute care
- Acute rehab
- Skilled nursing facility
- Observation

Nutrition/Counseling
- Counseling
- Enteral nutrition
- Infant formula
- Total parental nutrition

Outpatient therapy
- Occupational therapy
- Physical therapy
- Pulmonary/Cardiac rehab
- Speech therapy

Transportation
- Non-emergent ground
- Non-emergent air

Other (*specify*):

Provider information

Requesting provider name: NPI #

Phone: Fax:

Servicing provider name: NPI #

Same as requesting provider Phone: Fax:

Servicing facility name: NPI #

Same as requesting provider Phone: Fax:

Member information

Member name: Date of birth: / / Gender: M F

Member ID # Member account/control #:

Member address: Phone:

Diagnosis/planned procedure information

Principal diagnosis and description:

ICD-10 codes:

Principal planned procedure (*description and CPT/HCPCS code*):

# of units being requested: hours months days visits dosage

Secondary diagnosis and description:

ICD-10 codes:

Secondary planned procedure (*description and CPT/HCPCS code*):

# of units being requested: hours months days visits dosage

Services start date: / / **Services end date:** / /

CLEAR FORM