Residential Rehabilitation Services (RRS) First Clinical Review Form for In-Network Providers Only

TUFTS Health Plan
a Point32Health company

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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 / / Date range of requested sessions / / to / /

To ensure continuous authorization, requests must be received within one week before or after the previous authorization's end date. Use this form for the first clinical review; **subsequent reviews are to be completed via phone with a masters-level clinician from the RRS facility by calling 888-257-1985.**

Level of RRS

☐ Adult ☐ Family ☐ Transitional ☐ Youth ☐ Pregnant/Post-Partum ☐ Co-occuring/enhanced

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

Clinical contact name Clinical contact phone

Supervisor name Supervisor phone

Fax to send authorization to

Clinical Information

1. ICD-10 Alpha Numeric Diagnosis Code

   Alpha Numeric Diagnosis Code(s)

2. Is the member involved with state agencies? *(Select all that apply)* ☐ None ☐ DMH ☐ DCF ☐ DDS ☐ DYS

   ☐ Other

3. Progress since admission:

4. Attach the most recent individualized recover treatment/service plan as outlined in the Performance Specifications for this level of care.

5. Outline progress on goals and interventions to achieve goals and address barriers below:

6. How does member currently meet ASAM criteria for RRS?

Risk Ranking:

4	This rating would indicate issues of **utmost severity.** The patient would present with critical impairments in coping and functioning, with signs and symptoms, indicating an "**imminent danger**" concern.	**High**
3	This rating would indicate a **serious issue** or difficulty coping within a given dimension. A patient presenting at this level of risk may be considered in or near "**imminent danger**."	**Moderate**
2	This rating would indicate **moderate difficulty** in functioning. However, even with moderate impairment, or somewhat persistent chronic issues, relevant skills, or support systems may be present.	
1	This rating would indicate a **mild difficulty issue**, or present minor signs and symptoms. Any existing chronic issues or problems would be able to be resolved in a short period of time.	**Low**
0	This rating would indicate a **non-issue or very low-risk issue**. The patient would present no current risk and any chronic issues would be mostly or entirely stabilized.	

Dimension 1: Acute Intoxication and/or Withdrawal Potential

Check one risk rating: 1 2 3 4
As evidenced/demonstrated by these specific symptoms, behaviors, risks, needs, strengths, skills, barriers, resources:

Dimension 2: Biomedical Conditions/Complications

Check one risk rating: 1 2 3 4
As evidenced/demonstrated by these specific symptoms, behaviors, risks, needs, strengths, skills, barriers, resources:

Dimension 3: Emotional, Behavioral, or Cognitive Conditions and Complications

Check one risk rating: 1 2 3 4
As evidenced/demonstrated by these specific symptoms, behaviors, risks, needs, strengths, skills, barriers, resources:

Dimension 4: Readiness to Change

Check one risk rating: 1 2 3 4
As evidenced/demonstrated by these specific symptoms, behaviors, risks, needs, strengths, skills, barriers, resources:

Dimension 5: Relapse, Continued Use or Continued Problem Potential

Check one risk rating: 1 2 3 4
As evidenced/demonstrated by these specific symptoms, behaviors, risks, needs, strengths, skills, barriers, resources:

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Dimension 6: Recovery/Living Environment

Check one risk rating: 1 2 3 4

As evidenced/demonstrated by these specific symptoms, behaviors, risks, needs, strengths, skills, barriers, resources:

7. Attach After Care Plan.

8. Is Member receiving Medication Assisted Treatment (MAT)? Yes No

9. If yes, where is the treatment being administered?

Attestation

I attest that we are meeting the performance specifications for this level of care.

Signature Print name Date / /

CLEAR FORM