Out-of-Network Coverage at In-Network Level of Benefits Prior Authorization 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. Please fax the completed form to the Member's plan listed below:

For MEDICAL services requests *(use this table to identify the correct fax number)*

Harvard Pilgrim Health Plan Commercial products

Harvard Pilgrim Health Plan Commercial	Fax: 800-232-0816

Tufts Health Commercial Plans products

Tufts Health Commercial Plans	Fax: 617-972-9409

Tufts Health Public Plans products

Tufts Health Direct	Fax: 888-415-9055
Tufts Health Together	Fax: 888-415-9055
Tufts Health RITogether	Fax: 857-304-6404
Tufts Health One Care	Fax: 857-304-6304

For BEHAVIORAL HEALTH service requests *(use this table to identify the correct fax number)*

Harvard Pilgrim Health Plan Commercial products

Harvard Pilgrim Health Plan Commercial	Fax: 800-232-0816

Tufts Health Commercial Plans products

Tufts Health Commercial Plans	Fax: 617-972-9409

Tufts Health Public Plans products

Tufts Health Direct	Fax: 888-977-0776
Tufts Health Together	Fax: 888-977-0776
Tufts Health RITogether	Fax: 857-304-6404
Tufts Health One Care	Fax: 857-304-6304

Member and Provider Information

Please complete all fields on both pages and submit any supporting clinical documentation

1. Member name
Member ID # Date of birth (*mm/dd/yyyy*)

2. Requesting provider name
Requesting provider address (*street, city, state, ZIP*)
Requesting provider ID/NPI # Fax Phone

3. Out-of-network provider name
Out-of-network provider NPI # Fax Phone
Out-of-network provider address (*street, city, state, ZIP*)
Out-of-network provider Tax ID #
Out-of-network provider license number

Date of request (*mm/dd/yyyy*)

Out-of-network service requested
(e.g., office visit, therapy/treatment)

CPT code(s) for service requested

Medical/Surgical **Behavioral Health**

DSM 5 Diagnoses/ICD 10 code

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:**

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 provider in an **emergency department** and including an inpatient admission as a direct result of that emergency department treatment will be permitted up to 2 follow-up visits with the treating out-of-network specialist provider. **Please explain:**

Number of follow-up visits (limit 2): Additional clinical information for above scenarios:
The Member requires **outpatient psychotherapy** treatment with a licensed out of plan provider. **Please explain:**

Continuity of Care Requests (Commercial and Tufts Health Direct) for new Members or active/current Members when provider or facility disenrolls from the plan):

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. Please explain:**

Other. Please describe reason for requesting continuity of care:

Provider Signature: