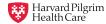
Out-of-Network Coverage at In-Network Level of Benefits and Continuity of Care Prior Authorization Form







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. **All fields are required.** 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	
Tufts Health Senior Products		
Tufts Health Medicare Preferred	Fax: 617-972-9409	
Tufts Health Senior Care Options	Fax: 617-673-0930	
Harvard Pilgrim Health Care Stride Medicare Advantage Plan		

Harvard Pilgrim Stride Medicare Advantage Fax: 866-874-0857

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	
Tufts Health Senior Products		
Tufts Health Medicare Preferred	Fax: 617-972-9409	
Tufts Health Senior Care Options	Fax: 617-673-0930	
Harvard Pilgrim Health Care Stride Medicare Advantage Plan		

Member and Provider Information

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

Harvard Pilgrim Stride Medicare Advantage Fax (Optum UBH): 844-512-9824

1. Please check the appropriate box (required information):

Patient is new to the Plan

Patient's provider/facility i

Patient's provider/facility is no longer in network

Other:

2. Member name:

Member ID # Date of birth (mm/dd/yyyy):

3. Requesting provider name	е:		
Requesting provider addre			
Requesting provider ID/NP	1#	Fax:	Phone:
4. Out-of-network provider r	name:		
Out-of-network provider NI	기#	Fax:	Phone:
Out-of-network provider ac	Idress (street, city, state, ZIP):		
Out-of-network provider Ta			
Out-of-network provider lic	ense number:		
Date of request (mm/dd/yyyy) :		
Service requested (e.g., office	e visit, therapy/treatment):		
CPT code(s) for service requ	ested:		
DSM 5 Diagnoses/ICD 10 co	ode:		
Medical/Surgical	Behavioral Health		
3			
	•		S (for all Point32Health lines of business):
The clinical expertise to addrect Choose all that apply:	ess the specific health care need	ds of the Member is not	available from any in-network provider.
	e medical condition and there i treatment. Please explain:	s no in-network provide	r with the necessary specialization, training,
	specialized medical procedu or expertise to perform the proc		in-network provider with the necessary
speaks, and it is the tre		tment is highly likely to	loes not speak, and no in-network provider be compromised due to the language barrier se explain:
	ent in a nursing home, or inpa		ng facility and cannot travel and in-network
reasonably available		iccess standards (30 r	r's diagnosis or medical condition are not niles from Member's primary residence)
admission as a direct re			y department and including an inpatient rmitted up to 2 follow-up visits with the treating

Additional clinical information for above scenarios:

The Member requires **outpatient psychotherapy** treatment with a licensed out of plan provider. **Please explain:**

Number of follow-up visits (limit 2):

Please include diagnosis, expected treatment duration and dates of surgery if scheduled. 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 (medical or behavioral health). Please explain: Other. Please describe reason for requesting continuity of care:

Continuity of Care Requests (Prior authorization is <u>not</u> required for Tufts Health Together and Dual Eligible Plans):