

Click [here](#) to reference the Denial of Coverage and Expedited Approval Form

Section I.

- List the member name, member ID#, Tufts Health Plan Medicare Preferred plan type (HMO or PPO), PCP name, PCP ID#, and IPA#.
- **Indicate the type of service/supply being requested, being as specific as possible. Also, indicate this information by selecting the most appropriate check box option.**
- Indicate if the request is for services that have not yet occurred (Pre-service), or if the services are still occurring (Concurrent).
- Indicate the name of the person making the request. Also, indicate who the requestor is by selecting the most appropriate check box option. An Appointment of Representation (AOR) is someone authorized to request on the member's behalf.
- If request is from someone other than the member, indicate if it is being made on the member's behalf.

Section II.

- Indicate the date and time that the initial request was received
- Note: From the time the initial request is received, regardless if a decision has been made, you have 10 days for standard requests, and 24 hours for expedited, to send the form to Tufts Medicare Preferred.**
- Indicate the name and title of the person who received the initial request.
 - Indicate the method of request by selecting the most appropriate check box option.
 - Indicate if the requestor asked for an expedited/fast decision, and if so, document in the requestor's own words on the Denial of Coverage & Expedited Approval Form (This is needed for CMS auditing purposes).
 - Indicate if the PCP/Medical Group processed the request as an expedited organization determination.
- Note: If a request for an expedited organization determination does not meet expedited criteria, the member/member representative must be informed, both verbally and in writing within 72 hours of receipt of the request, that the request will follow the standard time frame and that the requestor has the ability to file a grievance regarding this decision. Medical Groups are required to inform the requestor verbally, and fax the Form to Tufts Medicare Preferred within 24 hours of the request, so that the requestor can be informed in writing of the decision not to expedite and be informed of their expedited grievances rights.**

Note: Requests for expedited organization determinations must be honored if; The expedited request is either made or supported by a physician, or waiting for a standard organization determination may jeopardize the member's health, life, or ability to regain maximum function.

Section III.

- **If the PCP/Medical Group does not have the necessary information to make a decision select the "No" check box option, and indicate the reason for the delay.**
- Note: Tufts Medicare Preferred will issue an extension notice when/if applicable.
- If the PCP/Medical Group does have the necessary information to make a decision select the "Yes" check box option, and document the specific information into the member's medical record, as well as the Medicare coverage guideline used to support the decision.
- Note: Tufts Medicare Preferred may need these medical records per CMS guidelines.**

Section IV. (If detail does not fit on page attach additional sheets if necessary)

- Indicate if the request was approved or denied by selecting the appropriate check box.
- If the Medical Group denied the request indicate the rationale by selecting the most appropriate check box option.
- List the preferred providers if the rationale is "Out of referral circle" or "Out of plan."
- Fill out the table provided if the rationale is "Exhaustion of 100-day SNF benefit."
- Indicate the name(s) of the facility, the date(s) of admission, the date(s) of discharge, the discharge disposition, and the number of days (if applicable).
- Indicate the title and or number of the Medicare coverage guidelines used to make the decision or include/fax guidelines with the Form.

Section V.

- Indicate the date and time that the physician made the organization determination (decision).
 - Indicate the date and time that the requestor was verbally notified of the organization determination, and given appeal rights (if applicable).
 - Indicate the date and time that the requesting provider was verbally notified of the decision and his/her ability to discuss with the decision maker (if applicable).
 - Print the name of the physician who made the organization determination (decision).
 - The physician who made the decision must sign the Form at the time that the decision was made.
- Note: Signature stamps or pre-signed copied Forms will not be accepted.**
- The person filling out the Form must print their name, sign the Form, and list their direct ph. & Fax #'s.