Adult Day Health-Enhanced Services
Prior Authorization Form

Please return completed form to the Utilization Management Department at (401)459-6023.
Please refer to Neighborhood's *Clinical Medical Policy* which is available on our Neighborhood web site, www.nhpri.org for more detailed information about this benefit, authorization requirements, and coverage criteria.

MEMBER INFORMATION		
Member's Name:	Member's ID #:	Member's DOB:
PROVIDER INFORMATION		
Provider's Name:	Provider NPI #:	Date Request Sent:
Date of Service:	Previous Auth #:	Place of Service (City/Town)/Facility:
Provider Contact and Phone #:	Provider's Fax #:	Ordering MD:
CLINICAL INFORMATION (Please include all clinical information)		
Diagnosis & Diagnosis Code:	Procedure & Procedure Code:	

RECIPIENT GOALS: (Explain recipient's individualized goals for enhancing his/her functioning and/or maintaining/improving his/her quality of life through services provided at the facility.)

_____

_____

DATE OF LAST PHYSICAL EXAM: _____

REQUESTED SERVICES: Based on the provider evaluation and assessment, the following services are requested *(Check all that apply under both "Skilled "and "Non-Skilled Care")*:

☐ **Skilled Care*** ****Please note: A physician/licensed provider order is required for those members receiving skilled care***

☐ *At least one skilled service by a Registered, Professional Nurse (RN) or a Licensed Practical Nurse (LPN).*

☐ **Non Skilled Care**

☐ *At least two (2) Activities of Daily Living (ADL).*

☐ *At least one (1) Activity of Daily Living which requires a two-person assist to complete the ADL.*

☐ *At least 3 Activities of Daily Living when supervision and cueing are needed to complete the ADL's identified.*

☐ *An individual who has been diagnosed with Alzheimer's disease or other related dementia, or a mental health diagnosis, as determined by a physician, and requires regular staff interventions due to safety concerns related to development risk or other behaviors and inappropriate behaviors that adversely impact themselves or others. Such behaviors and interventions must be documented in the participant's care plan and in the required progress notes.*

ATTENDANCE SCHEDULE: Anticipated Number of Hours Per Day full or half day):

Sunday: Monday: Tuesday: Wednesday: Thursday: Friday: Saturday:

Authorization is not a guarantee of payment.

NOTE: IF SKILLED, SIGNATURE REQUIRED BY A PHYSICIAN/ LICENSED PROVIDER		
Signature of Physician and/or Licensed Provider (required for skilled service):		**Date:**
NEIGHBORHOOD DECISION		
Authorization #:	Dates of Service:	Services Approved:
UM Initials:	**Notification Date:**	☐ **Not Approved - Letter to Follow**