Please return completed form to DMEnsions at (248)844-3824.

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:	Supplier ID or 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 provide all supporting documentation and MD orders)		

Diagnosis:	Diagnosis Code:

PROVIDER Section						NEIGHBORHOOD Section
Qty	Description and Code Info	Rent or Purchase	Date(s) of Service	CMN Date	Referral #	Approved or Denied (If denied, letter to follow)

NOTE: THIS FORM MUST BE SIGNED BY A PHYSICIAN	
Signature of Treating Physician:	Date:

NEIGHBORHOOD DECISION ***Authorization is not a guarantee of payment.***		
Authorization #:	Dates of Service:	Services Approved:
UM Initials:	Notification Date:	☐ Not Approved - Letter to Follow

Updated 7/2011, 7/2012, Revised 6/2013, 2/2016, 10/2016