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:	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			
CPT Code:	Units:	CPT Code:	Units:
Diagnosis:		Diagnosis Code:	

Other Insurance/Treatment Information: ❑ COB ❑ MVA Other Insurer Information _____

Has the member received services elsewhere within the last 12 months?

If so, when? _____ Where? _____ # Visits _____

Request Information for Initial Request: ❑ PT ❑ OT ❑ ST

Is this related to a recent or upcoming surgery? ❑ Yes - Date _____ If yes, please send sx protocol or MD orders Please Select One

❑ Evaluation Only Start Date:_____Thru Date:____

❑ Evaluation + 8 visits

Request Information for Continued Visits: ❑PT n OT n ST

Initial Evaluation Date: _____ Number of requested visits: _____

Start Date: _____ Thru Date: ___

Number of previous authorized visits: _____ Number of visits used to date: _____

Number of cancelled or no show: _____

Please submit this form with initial evaluation and most recent progress notes and /or re-assessment. Submitted documentation should include the following:

* Frequency & Duration
* Progress towards goals
* Home exercise Program
* Modalities of treatment

** Page 2 of this form "Request to Supplement IE or IEP Services" is required if child has neurodevelopment disorder*

NOTE: THIS FORM MUST BE SIGNED BY A THERAPIST	
Signature of Treating Therapist:	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

Request to Supplement EI or IEP Services

Instructions: Please complete page 1and then this additional page if child is under 3 years old or is of school age and has a neurodevelopment disorder.

Requested services which are above and beyond what is being provided by an IEP from the school department or Family Service Plan (FSP) from the Department of Health Early Intervention Program, must be medically necessary to be covered by Neighborhood. Please refer to our website, www.nhpri.org to review our Clinical Medical Policies for Outpatient Therapies for Members with Special Needs.

Note: If request is for evaluation only, check yes ❑

If child is < 3 years old, please provide information on Early Intervention:

❑Received previously ❑Currently receiving ❑Has been referred

If child has a neurodevelopment disorder and is of school age, please provide information regarding an IEP?

❑ Received EI services previously

❑ Currently has IEP ❑ Has been referred

Services child is currently receiving through Early Intervention or an IEP: ❑ **None**

PT	❑Daily	❑Weekly	❑Monthly	❑Other frequency
OT	❑Daily	❑Weekly	❑Monthly	❑Other frequency
ST	❑Daily	❑Weekly	❑Monthly	❑Other frequency

Goal(s) of requested evaluation and or treatment:

Home Program: ❑ **Yes** ❑ **No**

Relation of caregiver involved: _____

Estimated time period necessary for supplemented services:

❑ 1 month ❑ 3 months ❑ Other _____

For PT/OT:

How will lack of additional services affect activities of daily living ❑please be specific)?

For ST:

How will lack of additional services affect functional status ❑please be specific)?

NOTE: THIS FORM MUST BE SIGNED BY A THERAPIST		
Signature of Treating Therapist:		**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**