Please return completed form to DMEnsions at (248)-844-3824. Please refer to Neighborhood's *Clinical Medical Policy, if applicable* 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:		
Provider Contact and Phone #:	Provider's Fax #:	Ordering MD/ Phone #:
CLINICAL INFORMATION		
Diagnosis & Diagnosis Code:	❑New Request	❑Re-Certification Request

Please submit with supporting clinical documentation, Certificate of Medical Necessity (CMN)/Ordering Physician's signature.

HCPC	Description	NHP Allowable	Quantity Requested	Date Item Last Received	Decision	Amount Approved	Dates

Neighborhood Decision – Authorization is not a guarantee of payment.

Authorization #:_____ Date Sent:_____

Initials:_____ ❑Not Approved – Letter to Follow