Neighborhood Health Plan OF RHODE ISLAND™

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 of Request:
Date of Service:	Previous Auth #:	Place of Service (City/Town)/Facility:
Provider's Phone #:	Provider's Fax #:	Provider's Contact Name:

CLINICAL INFORMATION			
PT Code:	Units:	CPT Code:	Units:

Diagnosis:	**Diagnosis Code:**
Etiology/Specific Location of Pain	**Location of Proposed Treatment**

1) Please indicate if member has any of the following conditions:	❑ Radicular extremity pain resulting from failed back surgery syndrome ❑ Damage to peripheral nerves ❑ Chronic regional pain syndrome (reflex sympathetic dystrophy) ❑ Arachnoiditis	
2) Please check all that apply if applicable:	❑ Nerve injury secondary to stroke, spinal cord injury or other central nervous system disease ❑ Chronic malignant pain including: headaches, neuralgia, phantom limb pain, post herpetic neuralgia, intractable angina, diabetic neuropathy. ❑ Cervical spine trauma, disc herniation, or failed cervical spine syndrome ❑ Other: ____________________	
3) Please indicate if surgical intervention is an option for the patient	Yes ❑ No ❑	If no, please indicate reason:
4) Has the patient undergone a psychological or psychiatric evaluation?	Yes ❑ No ❑	

- Please submit clinical notes documentation of previous treatments and outcomes, which may include medications, surgery, physical therapy, and/or psychological treatment.
- Please submit documentation of trial of spinal cord stimulation with an external pulse generator for 3-7 days, and the results.

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

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