Neighborhood Health Plan OF RHODE ISLAND™

Weight Management Programs
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:	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			
CPT Code:	Units:	CPT Code:	Units:

Diagnosis:	**Diagnosis Code**	
Height:	Weight:	BMI:
Weight-Related Co Morbid Conditions:		

HISTORY OF PREVIOUS TREATMENT - PLEASE INDICATE PREVIOUS ATTEMPTS AND COMPLIANCE		
Nutritional Counseling:	Yes ❑ No ❑ Describe Compliance:	
Exercise:	Yes ❑ No ❑ Describe Compliance:	
Weight Reduction Program: If Yes, type of program:	Yes ❑ No ❑ Describe Compliance:	
Referral To: Miriam Hospital Weight Loss Program	Did the member attend the orientation?	Yes ❑ No ❑
Note: This is a one per lifetime benefit while a Neighborhood member	Has member ever attended the Miriam Weight Loss Program in the past?	Yes ❑ No ❑

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