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:**	

*HCPC code and two-digit modifiers
*(*the first digit identifies the ambulance's place of origin; the second digit identifies the destination.):*

Type of Ambulance Needed:	☐ Stretcher Ambulance	☐Wheelchair Ambulance

Who requested ambulance?_____
Place of Origin (e.g. name of hospital, group home, etc.)_____
Destination (e.g. name of nursing home, member's home, etc.)_____

MEDICAL NECESSITY INFORMATION

If available, please indicate treating clinician who provided the information and their location. If no information available, please leave blank and Neighborhood will obtain.

Name of Clinician: _____
Address of Clinician: _____

Medical Condition(s) which prevents safe transportation by any other means:	
Please indicate the purpose of transfer:	

Member's Name:		
Check all that apply:		❑Confined to bed (unable to get out of bed without assistance, unable to ambulate, and unable to sit in a chair or wheelchair) ❑ Unable to safely sit upright while in a wheelchair, or ❑Can tolerate a wheelchair but is medically unstable, or ❑ Requires specialized monitoring of mental status, airway monitoring, and/or cardiac monitoring, or ❑ Requires isolation due to disease or other exposure, ❑ Is a danger to self or others ❑ Other (please specify)_____
All three (3) of the following criteria must be met for all non-emergency wheelchair ambulance transportation to be considered medically necessary:		❑ The transportation is for the member to receive medically necessary care. ❑ The member can tolerate a wheelchair but has no capacity to mobilize outside of the house to the curb for EDS transportation pick up, and ❑ There is no caretaker/family available to transport member or to bring them to the curb.
NEIGHBORHOOD DECISION ***Authorization is not a guarantee of payment.***		
Authorization #:	Dates of Service:	Services Approved:
UM Initials:	Notification Date:	❑ Not Approved - Letter to Follow