Neighborhood Health Plan OF RHODE ISLAND™

New Request ❑ Re-Certification Request -Auth # ❑ Change Place of Service

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 detailed information about this benefit, authorization requirements, and coverage criteria 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		
Agency's Name:	Agency's NPI #:	Date Request Sent:
Date of Service:	Previous Auth #:	Place of Service (City/Town)/Facility:
Agency's Contact and Phone #:	Agency's Fax #:	Ordering MD & Phone:

CLINICAL INFORMATION	
Diagnosis & Diagnosis Code:	Procedure & Procedure Code

Place of Service:
❑ Home
❑ Hospital In-Patient: (Please list)________________________
❑ SNF (Please list)___________________________________
❑ Philip Hulitar

Dates of Service: From_______________ To:_______________________________

List all Durable Medical Equipment (Provided under Hospice Benefit):
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____

For DME items not provided under Hospice, Please call Neighborhood Reviewer listed below at (401) 459-6060. List brief summary of case:
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____
____

~~ NOTE: THIS FORM MUST BE SIGNED BY A REGISTERED NURSE ~~

PER EOHHS, Neighborhood cannot pay for services provided by individuals legally responsible for the member.

I attest that contracted services provided to this member will not be rendered by a person that is legally responsible for the member.

Signature of Registered Nurse:____ **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**