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

CLINICAL INFORMATION			
CPT Code:	Units:	CPT Code:	Units:
Diagnosis:		Diagnosis Code:	

Other Insurance/Treatment Information: ❑ COB ❑ MVA Other Insurer Information_____

Has the member received services elsewhere within the last 12 months?

If so, when?_____Where?_____# Visits_____

Request Information for Initial Request: ❑ PT ❑ OT ❑ ST

Is this related to a recent or upcoming surgery? u Yes – Date _____ If yes, please send sx protocol or MD orders

Please Select One

❑ Evaluation Only Start Date: _____ Thru Date: _____

❑ Evaluation + 8 visits

Request Information for Continued Visits: ❑ PT ❑ OT ❑ ST

Initial Evaluation Date:_____ Number of requested visits: _____ Start & Thru Date:_____

Number of previous authorized visits:_____ Number of visits used to date:___

Number of cancelled or no show:_____

Please submit this form with initial evaluation and most recent progress notes and /or re-assessment. Submitted documentation should include the following:

❑ Frequency & Duration ❑Home exercise Program
❑ Progress towards goals ❑Modalities of treatment

NOTE: THIS FORM MUST BE SIGNED BY A THERAPIST	
Signature of Treating Therapist:	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