

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:	Provider 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		
Diagnosis & Diagnosis Code:	Reason for initial test in a Facility:	
Patient's H/W/BMI	<input type="checkbox"/> Pediatric/Adolescent	
Epworth Sleepiness Score	<input type="checkbox"/> Cardiac disease (CHF NYHA 3 or 4, uncontrolled arrhythmia, pulmonary hypertension, recent (6months)MI	
Comorbid conditions	<input type="checkbox"/> Chronic Pulmonary disease - COPD req oxygen, obesity hypoventilation, lung disease uncontrolled by medical therapy	
Test Requested: CPT CODE:	<input type="checkbox"/> Neurologic d/o – previous CVA/TIA, nocturnal seizures, Parkinson's, AML, neurodegenerative disorders	
<input type="checkbox"/> Attended full channel nocturnal polysomnography (NPSG)/laboratory sleep test (LST)	Complex sleep disorder:	
<input type="checkbox"/> Multiple sleep latency testing (MLST) (only for narcolepsy)	<input type="checkbox"/> Narcolepsy	
Split night study: CPT CODE	<input type="checkbox"/> Parasomnias	
<input type="checkbox"/> AHI \geq 40 in the first 2 hours	<input type="checkbox"/> Periodic limb movement disorder	
<input type="checkbox"/> CPAP nearly/eliminates respiratory events during non/REM sleep	<input type="checkbox"/> Central sleep apnea	
<input type="checkbox"/> CPAP titration > 3hours	<input type="checkbox"/> BMI \geq 50	
<input type="checkbox"/> CPAP titration CPT CODE:	<input type="checkbox"/> Previous Home testing inconclusive	
	<input type="checkbox"/> Lack of mobility/dexterity	
	<input type="checkbox"/> Cognitive impairment	
	<input type="checkbox"/> Other	
Reason for repeat NPSG/LST:		
<input type="checkbox"/> Assess continued need for CPAP	<input type="checkbox"/> Assess need to change settings for positive airway pressure	
<input type="checkbox"/> Assess because of failed APAP/CPAP or symptom recurrence	<input type="checkbox"/> Confirm the presence of OSA prior to upper airway surgery	
<input type="checkbox"/> Failed split night NPSG	<input type="checkbox"/> Other	
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:	<input type="checkbox"/> Not Approved - Letter to Follow