Neighborhood Health Plan OF RHODE ISLAND™

Wound/Hyperbaric
Prior Authorization Form

***If Requesting both services, please fill out both sections**

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:	Procedure & Procedure Code:	

WOUND TREATMENT ONLY

Number Units:_____From:_____ To:_____

❑ **Please attach all patients clinical information**

HYPERBARIC TREATMENT ONLY

CPT:_____ **Units:**_____ **From:**_____ **To:**_____
_____ _____ _____ _____
_____ _____ _____ _____

❑ **Please attach all patient's clinical information** For Diabetic Wounds, please include the following:

- ❑ 30 Day Standard Wound Therapy
- ❑ Evidence of Osteomyelitis/Gangrene
- ❑ Documentation of Glucose Control, Vascular Status and Previous Debridement
- ❑ Wagner Classification

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**