Certificate of Medical Necessity
Prior Authorization Form

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:	

NOTE: For Absorbent Products (diapers), complete first page only.

Medical/Surgical History	Dates

Requested equipment (to include all accessories). May attach list.	Size	Quantity	Date of Service	Rent or Purchase

Duration of need _______ months ☐ 1 year ☐ Indefinite ☐ Other ________________________

Prognosis ______________________________

Indicate status of condition: ☐ Permanent ☐ Progressive ☐ Temporary, full recovery expected

Ordering practitioner signature ______________________________________ *Date* ____________

Is this equipment replacing a similar piece of equipment? ☐ Yes ☐ No

If yes, please justify ____

____

*List current equipment in member's home**

Rent or Purchased

____________________ ____________________
____________________ ____________________
____________________ ____________________
____________________ ____________________

*If this is new equipment, please detail why this equipment & accessories are medically needed. ***PLEASE INCLUDE ANY AVAILABLE PICTURES, BROCHURES, SPECIFICATIONS.***

____
____
____
____
____

Place where equipment will be used ☐ home ☐ work ☐ school ☐ other

Has equipment been tried for accessibility and appropriateness? ☐ Yes ☐ No

If no, explain ____

How will changes in height and weight affect this equipment? ____________________

____

Current schedule and location of therapies

Physical Therapy	☐ School-based ☐ Daily	☐ Outpatient ☐ Weekly	☐ Early Intervention ☐ Monthly	 ☐ Other ____________
Occupational Therapy	☐ School-based ☐ Daily	☐ Outpatient ☐ Weekly	☐ Early Intervention ☐ Monthly	 ☐ Other ____________
Speech Therapy	☐ School-based ☐ Daily	☐ Outpatient ☐ Weekly	☐ Early Intervention ☐ Monthly	 ☐ Other ____________

NOTE: THIS FORM MUST BE SIGNED BY A PHYSICIAN		
Signature of Treating Physician:		**Date:**
NEIGHBORHOOD DECISION		
Authorization #:	Dates of Service:	Services Approved:
UM Initials:	**Notification Date:**	❑ **Not Approved - Letter to Follow**