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 ID # (Please call Provider Services for your ID #):	Date of Request:
Date of Service:	Previous Auth #:	Place of Service (City/Town)/Facility:
Provider's Phone #:	Provider's Fax #:	Provider's Contact Name:

CLINICAL INFORMATION	
Diagnosis & Diagnosis Code:	Procedure & Procedure Code:
1. Is the patient pregnant and in the second or third trimester of pregnancy?	Yes ❑ No ❑ If yes, due date:
2. Is the patient currently receiving treatment for any acute conditions or trauma?	Yes ❑ No ❑ Diagnosis
3. Is the patient scheduled f or surgery or hospitalizations during the next 90 days?	Yes ❑ No ❑ If yes, list hospital and type of surgery or treatment scheduled:
4. Is the patient involved in a course of chemotherapy, radiation therapy,	Yes ❑ No ❑ Cancer Therapy or Terminal Care Please describe:
5. Is the patient a candidate for an organ transplant?	Yes ❑ No ❑
6. Is the patient receiving treatment as a result of a major surgery?	Yes ❑ No ❑ Surgical Procedure:
7. Please describe the condition and treatment plan for which the patient requests Continuity of Care:	
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**