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

The test must be for the benefit of the member in that the test results will have an impact on and make a change in the member's clinical management.
The sensitivity of the test must be greater than the clinical pre-test probability of the diagnosis.

Diagnosis & Diagnosis Code:	Procedure & Procedure Code:

Medical Necessity -	1. Is the requested test for a specific genetic defect, such as Fragile X, or is it a screening test, such as the microarray? Please describe.	______________________ ______________________
	2. If the test is positive how will that affect the member's clinical management?	______________________ ______________________
	3. If the test is negative, how will that affect the member's clinical management?	______________________ ______________________
	4. Is Test FDA Approved:	Yes ❑ No ❑
Genetic Laboratory Information	Name of Genetic Test:	Test Code (if applicable):
	Name of Lab:____________________ & Contact Name________________ Address______________________ Phone #______________ & Fax #______________	

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**