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		
Agency's Name:	Agency's NPI #:	Date Request Sent:
Date of Service:	Previous Auth #:	Place of Service (City/Town)/Facility:
Agency's Contact and Phone #:	Agency's Fax #:	Ordering MD & Phone:

CLINICAL INFORMATION	
Diagnosis & Diagnosis Code:	Procedure & Procedure Code:
Skilled Nurse Assessment Required – Documents Attached ❑ Yes ❑ No	
Brief Summary of Care: ______________________________ ______________________________	

Respiratory/Cardiac Status	Ventilator	❑ Yes ❑ No < 12 hrs/day ❑ Yes ❑ No > 12 hrs/day
	Oxygen Therapy	❑ Yes ❑ No
	Aspiration/Reflux precautions (No trach or vent)	❑ Yes ❑ No
	Suctioning (No trach or vent)	❑ Yes ❑ No
	Apnea monitor/pulse ox	❑ Yes ❑ No
	Trach Care	❑ Yes ❑ No
Nutrition	Tube Feedings	❑ Yes ❑ No
	G-Tube Care	❑ Yes ❑ No
	Difficulty/prolonged oral feeds	❑ Yes ❑ No
Neurological	Cognitively Impaired (age > 19 yrs)	❑ Yes ❑ No
Medications/IV's	Daily Meds (q8/hr or less)	❑ Yes ❑ No
Elimination/Skin Care	Catheterization	❑ Yes ❑ No
	Ostomy Care	❑ Yes ❑ No
	Decubitus/Wound care	❑ Yes ❑ No
Social	Have additional disabled individual in home that caregiver is responsible for	❑ Yes ❑ No

# of Hours Per Week ____________	**Dates of Service: From ________ To ________**
NOTE: THIS FORM MUST BE SIGNED BY A REGISTERED NURSE	
Signature of Registered Nurse:	**Date:**

NEIGHBORHOOD DECISION		
Authorization #:	Dates of Service:	Services Approved:
UM Initials:	**Notification Date:**	**❑ Not Approved - Letter to Follow**