Home Care Services Prior Authorization Form

☐ New Request ☐ Re-Certification Request -Auth #____________ ☐ Change Place of Service

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:
Medical History ____________	
Plan of Care (submit clinical notes) ____________	

Check One: ☐ More Visits ☐ Date Extension Reason: ____________

Check all that apply:

Caregiver	☐ Willing	☐ Unwilling	☐ Able	☐ **Unable**
Client	☐ Willing	☐ Unwilling	☐ Able	☐ **Unable**

Knowledge/skills: ____________ Early Intervention Program: ☐ Yes - Date of Evaluation_______ ☐ No
Resources/support: ____________ Home Exercise Pgm: ☐ Learning ☐ Independent ☐ Not Progressing
Other Waiver Programs: ____________

Treatment Related to: ☐ Workers Compensation ☐ Motor Vehicle Accident ☐ Other

Last MD Visit: ____________ Next MD Visit: ____________ (*required*)**VISITS USED TO DATE:**____________

Services Requested:

# Of Visits		From	To
RN			
LPN			
HHA			
PT			
OT			
ST			

NOTE: THIS FORM MUST BE SIGNED BY A REGISTERED NURSE	
Signature of Treating RN:	**Date:**

NEIGHBORHOOD DECISION		
Auth #:	DOS:	Services Approved:
UM Initials:	Date:	❑ Not Approved - Letter to Follow

Updated 7/2011