



**Home Health Aide - Block Hours
Prior Authorization Form
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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 <input type="checkbox"/> Yes <input type="checkbox"/> No		

<p>Required Information:</p> <p>Member's Age: _____ weight: _____ height: _____</p> <p><i>*Activities of Daily Living with/ without cueing:</i></p> <p>Bath: (check one) I <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/></p> <p>Grooming: (check one) I <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/></p> <p>Dressing: (check one) I <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/></p> <p>Eating: (check one): I <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/></p> <p><i>*Bowel/Bladder:</i></p> <p>> 3 years old & incontinent? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>* Hours Requested Per Week: _____</p> <p>Dates of Service: from _____ to _____</p> <p>Hours primary caretaker available: _____</p> <p>Hours a day member is attending school: _____</p> <p>Extended School Year? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>*Mobility</p> <p>Ambulation (check one:) I <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/></p>
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Legend: I= Independent M= Moderate D= Dependant

How does this diagnosis impact primary caregiver's ability to care for member? _____
Brief description of member's Plan of Care: _____

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:	<input type="checkbox"/> Not Approved - Letter to Follow