



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:
-----------------------------	-----------------------------

- Place of Service:**
- Home
 - Hospital In-Patient: (Please list) _____
 - SNF : (Please list) _____
 - Philip Hulitar

Dates of Service: From _____ To: _____

List all Durable Medical Equipment (Provided under Hospice Benefit):

For DME items not provided under Hospice, Please call Neighborhood Reviewer listed below at (401) 459-6060.
 List brief summary of case:

Would you like this member to be referred to NHP Case Management? YES NO

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