Outpatient Pulmonary Rehab Program
Prior Authorization Form

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 NPI #:	Date Request Sent:
Provider Contact and Phone #:	Provider's Fax #:	Ordering MD:
CLINICAL INFORMATION		
Diagnosis & Diagnosis Code:	Procedure & Procedure Code:	

1. **Impact on Activities of Daily Living**
Please select which personal care activities are impacted by significant respiratory symptoms:

☐ Bathing ☐ Dressing ☐ Toileting ☐ Meals ☐ Transfers Bed/Chair

Level of Dyspnea (M1400)

☐ Patient is not short of breath
☐ Patient is short of breath when walking more than 20 feet or climbing stairs
☐ Patient is short of breath with moderate exertion (while dressing, using commode, walking less than 20 feet)
☐ Patient is short of breath with minimal exertion (eating, talking, performing other ADLs) At Rest (during day or night)

2. **Confirmation of Ability to Participate, and Smoking Status**
Please confirm:

☐ Member is not limited by another serious or unstable medical condition
☐ Member has sufficient level of cognition to participate and comprehend program material
☐ Member is motivated to participate
☐ Member is a non-smoker or agrees to stop smoking during the duration of the program and/or will enroll in a smoking cessation program while on the program.
☐ Barriers exist that preclude member from participating in the Miriam Outpatient Pulmonary Program. Please describe barriers:

_____
_____

3. **Services Requested**
Please select and indicate # visits for each:

☐ PT # of Visits ____
☐ OT # of Visits ____
☐ Resp Therapist # of Visits ____
☐ Other # of Visits ____

Dates of Service Requested – Program Start _____ Thru _____

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**