

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 ID # (Please call Provider Services for your ID #):	Date of Request:
Date of Service:	Previous Auth #:	Place of Service (City/Town)/Facility:
Provider's Phone #:	Provider's Fax #:	Provider's Contact Name:

CLINICAL INFORMATION

Diagnosis & Diagnosis Code:	Procedure & Procedure Code:
-----------------------------	-----------------------------

Etiology/Specific Location of Pain _____	Location of Proposed Treatment _____
--	--------------------------------------

1. Please indicate if member has any of the following conditions:	<input type="checkbox"/> Radicular extremity pain resulting from failed back surgery syndrome <input type="checkbox"/> Damage to peripheral nerves <input type="checkbox"/> Chronic regional pain syndrome (reflex sympathetic dystrophy) <input type="checkbox"/> Arachnoiditis	
2. Please check all that apply if applicable:	<input type="checkbox"/> Nerve injury secondary to stroke, spinal cord injury or other central nervous system disease <input type="checkbox"/> Chronic malignant pain including: headaches, neuralgia, phantom limb pain, post herpetic neuralgia, intractable angina, diabetic neuropathy. <input type="checkbox"/> Cervical spine trauma, disc herniation, or failed cervical spine syndrome <input type="checkbox"/> Other: _____	
3.) Please indicate if surgical intervention is an option for the patient	Yes <input type="checkbox"/> No <input type="checkbox"/>	If no, please indicate reason: _____
4.) Has the patient undergone a psychological or psychiatric evaluation?	Yes <input type="checkbox"/> No <input type="checkbox"/>	

- Please submit clinical notes documentation of previous treatments and outcomes, which may include medications, surgery, physical therapy, and/or psychological treatment.
- Please submit documentation of trial of spinal cord stimulation with an external pulse generator for 3-7 days, and the results.



Member Name:

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