



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:
Height:	Weight:	BMI:
Weight-Related Co Morbid Conditions:		
HISTORY OF PREVIOUS TREATMENT - PLEASE INDICATE PREVIOUS ATTEMPTS AND COMPLIANCE		
Nutritional Counseling:	Yes <input type="checkbox"/> No <input type="checkbox"/> Describe Compliance: _____	
Exercise:	Yes <input type="checkbox"/> No <input type="checkbox"/> Describe Compliance: _____	
Weight Reduction Program: If Yes, type of program: _____	Yes <input type="checkbox"/> No <input type="checkbox"/> Describe Compliance: _____	
Referral To: Miriam Hospital Weight Loss Program	Did the member attend the orientation?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Note: This is a one per lifetime benefit while a Neighborhood member	Has member ever attended the Miriam Weight Loss Program in the past?	Yes <input type="checkbox"/> No <input type="checkbox"/>
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:	<input type="checkbox"/> Not Approved - Letter to Follow