

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 detailed information about this benefit, authorization requirements, and coverage criteria 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

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|-----------------------------|----------------------------|
| 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:

~~~ NOTE: THIS FORM MUST BE SIGNED BY A REGISTERED NURSE ~~~

PER EOHHS, Neighborhood cannot pay for services provided by individuals legally responsible for the member.
I attest that contracted services provided to this member will not be rendered by a person that is legally responsible for the member.
Signature of Registered Nurse: _____ Date: _____

NEIGHBORHOOD DECISION - *Authorization is not a guarantee of payment.*

| | | |
|------------------|--------------------|--|
| Authorization #: | Dates of Service: | Services Approved: |
| UM Initials: | Notification Date: | <input type="checkbox"/> Not Approved - Letter to Follow |