Neighborhood Health Plan OF RHODE ISLAND™

Home Infusion
Prior Authorization Form

❑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:	

CPT/HCPC Codes	**Units**	**Dates of Service**

S Codes	**Units**	**Dates of Services**

J Codes	**Units**	**Dates of Service**

Skilled Nurse Visits	**# Visits**	**Dates of Service**

~ ~ 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:**	❑ **Not Approved - Letter to Follow**
Pharmacist's Initials:	**Date:**	