Outpatient Rehabilitation Adult
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 website, 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		
Therapy Facility Name:	**Therapy Facility NPI:**	**Date Request Sent:**
Date of Service:	**Previous Auth #:**	**Place of Service (City/Town)/ Facility:**
Therapy facility contact name and phone #:	**Therapy facility fax #:**	**Ordering MD:**

CLINICAL INFORMATION			
CPT Code:	**Units:**	**CPT Code:**	**Units:**
Diagnosis:		**Diagnosis Code:**	

Other Insurance/Treatment Information: ___COB __MVA Other insurance Information: _____________

Has the member received services elsewhere within the last 12 months? _____ Yes _____ No
If yes, when? _______________ Where? _______________

Information for continued visits **Please choose:** ☐ **PT** ☐ **OT** ☐ **ST**

Initial Evaluation Date: __________ **Number of requested visits:** ______

Start & Thru Date: _____________ **Number of previous authorized visits:**______

Number of cancelled or no show: ______

Please submit this form with initial evaluation and most recent progress notes and /or re-assessment. Submitted documentation should include the following:

☐**Frequency & Duration** ☐**Home Exercise Program** ☐ **Progress towards goals** ☐ **Modalities of treatment**

NOTE: THIS FORM MUST BE SIGNED BY A THERAPIST		
Signature of Treating Therapist:		**Date:**
NEIGHBORHOOD DECISION		
Authorization #:	**Dates of Service:**	**Services Approved:**
UM initials:	**Notification Date:**	☐ **Not Approved- Letter to Follow**

Neighborhood Health Plan of Rhode Island
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