OUTPATIENT SURGERY/PROCEDURE PRIOR AUTH REQUEST AND CHECKLIST

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:	Supplier ID or NPI #:	Date of Request:
Scheduled Date of Procedure:	Previous Auth #:	Name of Hospital / Facility:
Provider's Phone #:	Provider's Fax #:	Provider's Contact Name:
Name of Primary Care Practitioner (PCP):	PCP Phone #:	PCP Fax #

CLINICAL INFORMATION			
CPT Code:	Units:	CPT Code:	Units:

Diagnosis: **Diagnosis Code:**

Description of Procedure: _____

Please use the following checklist to ensure the appropriate clinical information is submitted with this request, to allow for a timely medical necessity determination.

Documentation of medical necessity for the requested procedure may include one or all of the following:

- ❑ Physician Office Notes
- ❑ Consults and all other evaluations
- ❑ Results of Diagnostic Testing
- ❑ Previous Treatment and Outcomes

NEIGHBORHOOD DECISION - *Authorization is not a guarantee of payment*		
Authorization #:	Dates of Service:	Services Approved:
UM Initials:	Notification Date:	q Not Approved - Letter to Follow