

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 NPI #:		Date Request Sent:
Date of Service:		Previous Auth #:		Place of Service (City/Town)/Facility:
Provider Contact and Phone #:		Provider's Fax #:		Ordering MD:
CLINICAL INFORMATION				
CPT Codes	Units	Levels	Anatomic location to be treated:	Anesthesia
			<input type="checkbox"/> Bilateral or <input type="checkbox"/> Unilateral <input type="checkbox"/> Left or <input type="checkbox"/> Right	<input type="checkbox"/> Local or <input type="checkbox"/> MAC
			<input type="checkbox"/> Bilateral or <input type="checkbox"/> Unilateral <input type="checkbox"/> Left or <input type="checkbox"/> Right	<input type="checkbox"/> Local or <input type="checkbox"/> MAC
			<input type="checkbox"/> Bilateral or <input type="checkbox"/> Unilateral <input type="checkbox"/> Left or <input type="checkbox"/> Right	<input type="checkbox"/> Local or <input type="checkbox"/> MAC
Diagnosis:			Diagnosis Code:	
Procedure requested:		<input type="checkbox"/> Epidural steroid injection – <input type="checkbox"/> Interlaminar or <input type="checkbox"/> Transforaminal <input type="checkbox"/> Spinal facet joint injection -- <input type="checkbox"/> Diagnostic or <input type="checkbox"/> Therapeutic <input type="checkbox"/> Sacroiliac injection <input type="checkbox"/> Radiofrequency nerve ablation <input type="checkbox"/> Other _____ <input type="checkbox"/> Fluoroscopy		
<p>Please attach clinical notes that includes ALL of the following:</p> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"><input type="checkbox"/> Last injection/Injection history</div> <div style="width: 33%;"><input type="checkbox"/> Relief from last injection</div> <div style="width: 33%;"><input type="checkbox"/> Provocative testing results</div> <div style="width: 33%;"><input type="checkbox"/> Previous physical therapy</div> <div style="width: 33%;"><input type="checkbox"/> Pain Medication used</div> <div style="width: 33%;"><input type="checkbox"/> Functional impairment</div> <div style="width: 33%;"><input type="checkbox"/> Comprehensive pain management treatment plan</div> </div>				

NOTE: THIS FORM MUST BE SIGNED BY A PHYSICIAN		
Signature of Treating Physician:		Date:
NEIGHBORHOOD DECISION		
<i>Authorization is not a guarantee of payment.</i>		
Authorization #:	Dates of Service:	Services Approved:
UM Initials:	Notification Date:	<input type="checkbox"/> Not Approved - Letter to Follow