

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:
Date of Service:		Previous Auth #:	Place of Service (City/Town)/Facility:
Provider's Phone #:		Provider's Fax #:	Provider's Contact Name:
CLINICAL INFORMATION			
PT Code:	Units:	CPT Code:	Units:
Diagnosis:		Diagnosis Code:	
Etiology/Specific Location of Pain		Location of Proposed Treatment	
1) Please indicate if member has any of the following conditions:		<input type="checkbox"/> Radicular extremity pain resulting from failed back surgery syndrome <input type="checkbox"/> Damage to peripheral nerves <input type="checkbox"/> Chronic regional pain syndrome (reflex sympathetic dystrophy) <input type="checkbox"/> Arachnoiditis	
2) Please check all that apply if applicable:		<input type="checkbox"/> Nerve injury secondary to stroke, spinal cord injury or other central nervous system disease <input type="checkbox"/> Chronic malignant pain including: headaches, neuralgia, phantom limb pain, post herpetic neuralgia, intractable angina, diabetic neuropathy. <input type="checkbox"/> Cervical spine trauma, disc herniation, or failed cervical spine syndrome <input type="checkbox"/> Other: _____	
3) Please indicate if surgical intervention is an option for the patient		Yes <input type="checkbox"/> No <input type="checkbox"/>	If no, please indicate reason:
4) Has the patient undergone a psychological or psychiatric evaluation?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
<ul style="list-style-type: none"> • Please submit clinical notes documentation of previous treatments and outcomes, which may include medications, surgery, physical therapy, and/or psychological treatment. • Please submit documentation of trial of spinal cord stimulation with an external pulse generator for 3-7 days, and the results. 			
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	