

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. Please remember: An authorization for services is not guarantee of payment.

Important Information for Payment: W-9 Forms are required in order to get reimbursed by Neighborhood for authorized services. If this has not previously been sent, please submit with this request.

MEMBER INFORMATION			
Member's Name:	Member's ID #:	Member's DOB:	
REFERRING PROVIDER INFORMATION			
Referring Provider's Name:	Referring Provider Phone/Fax:	Date of Request:	
OUT OF NETWORK PROVIDER INFORMATION			
Out of Network Organization Name:	Organizational NPI:	Date of Service:	
Previous Auth #:	Place of Service (City/Town)/Facility:	Address for Remittance Advice/Payment:	
Treating Practitioner Name:	Specialty Type:	Phone #:	Fax #:
CLINICAL INFORMATION (Please Attach Clinical Notes)			
Diagnosis & Diagnosis Code:		Procedure & Procedure	
Any Medications/Pharmaceuticals associated with this request? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please fax this request to our Pharmacy department: 1-844-639-7906	
PURPOSE FOR REQUEST:			
<input type="checkbox"/> Consultation (Follow-up Visit)		<input type="checkbox"/> *Imaging	
<input type="checkbox"/> Consultation (One Visit) Reason		<input type="checkbox"/> *Lab/ Pathology	
<input type="checkbox"/> Second Opinion (One visit) Reason		<input type="checkbox"/> Inpatient (Elective Admission)	
<input type="checkbox"/> Other			
Has Member already been evaluated by NHPRI Specialist: <input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="checkbox"/> If yes please provide Name & Number of Specialist:			
NEIGHBORHOOD DECISION			
Authorization is not a guarantee of payment.			
Authorization #:	Dates of Service:	Services Approved:	
UM Initials:	Notification Date:	<input type="checkbox"/> Not Approved - Letter to Follow	

*It is expected that imaging, lab, pathology, and therapy services will be performed in Neighborhood's Network with the results sent to the primary care provider, unless otherwise authorized.

*Neighborhood has collaborated with Evicore Healthcare for prior authorization of all outpatient elective MRI, CT, NCM/MPI and PET studies. Please visit the Evicore web site for more information www.evicore.com.