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 (Please include all clinical information)		
Diagnosis & Diagnosis Code:	Procedure & Procedure Code:	

Please note: for full description of each Tier please refer to Assisted Living Services Description and Certification Standards found at www.nhpri.org
Check the box that applies to level of care the member is approved for and you are requesting.

☐ **Tier A Services**

☐ **Tier B Services**

☐ **Tier C Services**

Authorization is not a guarantee of payment

Signature of Treating Physician or Licensed Provider:		**Date:**
NEIGHBORHOOD DECISION		
Authorization #:	Dates of Service:	Services Approved:
UM Initials:	**Notification Date:**	☐ **Not Approved - Letter to Follow**