

Please return completed form to the Utilization Management Department at fax number (401) 459-6023. Please refer to our Neighborhood web site, [www.nhpri.org](http://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			
Requesting Facility/Provider Name:	Contact Name:	Contact Phone#:	Contact Fax#:
Name of Ordering Physician:	Level of Care (select one option):		
Date of Admission (if known):	SNF Skilled	SNF Custodial	Acute Rehab      LTAC
Accepting Facility Name (if known and different than requesting facility):	Contact Name:	Contact Phone#:	Contact Fax#:
Accepting Facility NPI #:			
CLINICAL INFORMATION			
Diagnosis Description:	1.	ICD-10 Diagnosis Code:	1.
	2.		2.
<b>Purpose of referral</b> (check all that apply): <ul style="list-style-type: none"> <li><input type="radio"/> Rehab Therapy (PT/OT/ST)</li> <li><input type="radio"/> Skilled nursing (IV meds/complex wound care, etc...)</li> <li><input type="radio"/> Respiratory - Vent, Trach</li> <li><input type="radio"/> Custodial, non-skilled services</li> </ul>	Please include any important documents of medical necessity for the requested level of care. Such as rehab evaluation, skilled or non-skilled needs, progress notes, discharge planning notes. <ul style="list-style-type: none"> <li><input type="radio"/> <b>Clinical Notes Attached</b></li> </ul>	Additional Comments:	
NEIGHBORHOOD DECISION			
<i>Authorization is not a guarantee of payment.</i>			
Authorization #:	Dates of Service:	Services Approved:	
UM Initials:	Notification Date:	<input type="radio"/> Not Approved - Letter to Follow	