Neighborhood Health Plan OF RHODE ISLAND™

Behavioral Health Services
Prior Authorization Form

Please return completed form to the Utilization Management Department at (401)459-6023.
Please refer to Neighborhood's Clinical Medical Policies, which are available on our website, www.nhpri.org, for more detailed information about these benefits, authorization requirements, and coverage criteria.

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.

REMINDER: Prior authorization requests should only be submitted for out-of-network (OON) services, non-covered services, and for administratively necessary days.

*****Indicates required field(s)

Member Information* (All fields are required)			
Member's Name:		Member's ID #:	Member's DOB:
In-Network Referring Provider Information* (All fields are required for OON requests)			
Name:		Phone:	Fax:
Servicing Provider/Organization Information* (All fields are required)			
Name:		NPI:	Date(s) of Service:
Treating Practitioner Name and NPI:		Specialty Type:	CMS Place of Service Code for Billing:
Phone:	Fax:	Contact Name:	Previous Authorization(s):
Address for Remittance Advice/Payment:			*Are the requested services court ordered? ☐ **YES** ☐ **NO** **If yes, provide copy of court order**

Clinical Information (Please Attach Clinical Notes)

*Primary Diagnosis Code(s):	
*For OON Requests: Has the member already been evaluated by a NHPRI Provider? ☐ YES ☐ NO If yes, please provide the name & number of the provider: ****Provide reason for Out of Network referral and supporting documentation from In Network Provider.**	Medications/Pharmaceuticals associated with this request? ☐ YES ☐ NO If yes, please fax this request to our Pharmacy Department at 1-844-639-7906. *Member is a: ☐ New Patient ☐ Existing Patient – Start of Care Date: _____

***REQUESTED SERVICE & CODES**

REQUIRED: CPT/HCPCS CODES, UNITS, & SERVICES GRID

CPT/HCPCS Code	Units/Visit Frequency	CPT/HCPCS Code	Units/Visit Frequency

SERVICES GRID	
Inpatient Services: ☐ Acute Residential Treatment (not Substance Use) ☐ Crisis Stabilization/Observation ☐ Inpatient Acute Hospitalization ☐ Inpatient Substance Use Disorder Services (ASAM Level 4) ☐ Mental Health Psychiatric Rehabilitative Residence (MHPRR) ☐ Non-Hospital/ Community Based Detox ☐ Partial Hospitalization (PHP) ☐ SUD Residential - ASAM Level 3.1 ☐ SUD Residential - ASAM Level 3.3 ☐ SUD Residential - ASAM Level 3.5 ☐ Administratively Necessary Days (Lack of a safe discharge plan/placement) ☐ Boarding Days (In medical bed but awaiting psych bed) ☐ Other Service (complete field below) ***REQUIRED: Is this a transfer between facilities?** **☐ YES ☐ NO**	**Outpatient Services:** ☐ Applied Behavioral Analysis (ABA) ☐ Assertive Community Treatment ☐ CCBHC ☐ Community Based Narcotic Treatment ☐ Day/Evening Treatment ☐ Electro-Convulsive Therapy (ECT) ☐ Enhanced Outpatient Services ☐ Health Home Opioid Treatment Program ☐ Home Based Treatment Services (HBTS) ☐ Evidence Based Practice ☐ Personal Assist Services & Supports (PASS) ☐ Respite ☐ Integrated Health Home ☐ Intensive Outpatient Treatment ☐ Psychological and Neuropsych Testing ☐ Supported Employment ☐ Therapy – CBT, Individual, Family, Group ☐ Transcranial Magnetic Stimulation (TMS) ☐ Other Service (complete field below)
Other Service(s) Description:	

ATTENTION: Please complete all fields on the form and submit all clinical documents. Documentation may include MD orders, physician office notes, consults and all other evaluations, results of diagnostic testing, previous treatment outcomes, and patient's clinical information. This will help us process your request without delay. Failure to provide sufficient information will delay your request as it will be returned.

Requests submitted without clinical information may have the decision delayed as the request is incomplete.

Authorization is not a guarantee of payment.

Authorization #:	**Dates of Service:**	**Services Approved:**
UM Initials:	**Notification Date:**	☐ **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 Health Plan of Rhode Island
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