Neighborhood Health Plan OF RHODE ISLAND™

**Outpatient Rehabilitation Adult**
**Prior Authorization Form**

**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 website, 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** | | |
| **Therapy Facility Name:** | **Therapy Facility NPI:** | **Date Request Sent:** |
| **Date of Service:** | **Previous Auth #:** | **Place of Service (City/Town)/ Facility:** |
| **Therapy facility contact name and phone #:** | **Therapy facility fax #:** | **Ordering MD:** |

| **CLINICAL INFORMATION** | | | |
|---|---|---|---|
| **CPT Code:** | **Units:** | **CPT Code:** | **Units:** |
| | | | |
| | | | |
| | | | |
| **Diagnosis:** | | **Diagnosis Code:** | |

Other Insurance/Treatment Information: ___COB __MVA Other insurance Information: _____

Has the member received services elsewhere within the last 12 months? ____ Yes _____ No
If yes, when? _____ Where? _____

**Information for continued visits** **Please choose:** ☐ **PT** ☐ **OT** ☐ **ST**

**Initial Evaluation Date:** _____ **Number of requested visits:** _____

**Start & Thru Date:** _____ **Number of previous authorized visits:**

**Number of cancelled or no show:** _____

**Please submit this form with initial evaluation and most recent progress notes and /or re-assessment. Submitted documentation should include the following:**

☐**Frequency & Duration** ☐**Home Exercise Program** ☐ **Progress towards goals** ☐ **Modalities of treatment**

| **NOTE: THIS FORM MUST BE SIGNED BY A THERAPIST** | | |
|---|---|---|
| **Signature of Treating Therapist:** | | **Date:** |
| **NEIGHBORHOOD DECISION** | | |
| **Authorization #:** | **Dates of Service:** | **Services Approved:** |
| **UM initials:** | **Notification Date:** | ☐ **Not Approved- Letter to Follow** |

**Neighborhood Health Plan of Rhode Island**
**910 Douglas Pike Smithfield, RI 02917 Tel: 800-963-1001 Fax: 401-459-6023**