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? □Yes □No	**If yes, please fax this request to our Pharmacy department: 1-844-639-7906**

PURPOSE FOR REQUEST:	
□ Consultation (Follow-up Visit)	□ *Imaging
□ Consultation (One Visit) Reason	□ *Lab/ Pathology
□ Second Opinion (One visit) Reason	□ Inpatient (Elective Admission)
□ Other	

Has Member already been evaluated by NHPRI Specialist: □Yes □ No

□ **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:	□ 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.