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:	Supplier ID or NPI #:	Date of Request:
Date of Service:	Previous Auth #:	Place of Service (City/Town)/Facility:
Provider's Phone #:	Provider's Fax #:	Provider's Contact Name:
Name of Primary Care Practitioner (PCP):	PCP Phone #:	PCP Fax #

CLINICAL INFORMATION			
CPT Code:	Units:	CPT Code:	Units:
Diagnosis:		Diagnosis Code:	
Purpose of referral:	Procedure:	Other:	

NOTE: THIS FORM MUST BE SIGNED BY A PHYSICIAN	
Signature of Treating Physician:	Date:

NEIGHBORHOOD DECISION ***Authorization is not a guarantee of payment.***		
Authorization #:	Dates of Service:	Services Approved:
UM Initials:	Notification Date:	☐ Not Approved - Letter to Follow