Neighborhood Health Plan OF RHODE ISLAND™

SNF / Acute Rehab / LTAC
Initial Request ONLY
Authorization Request Form

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 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: Date of Admission (if known):	Level of Care (select one option): **SNF Skilled** **SNF Custodial** **Acute Rehab** **LTAC**		
Accepting Facility Name (if known and different than requesting facility): Accepting Facility NPI #:	Contact Name:	Contact Phone#:	Contact Fax#:

CLINICAL INFORMATION			
Diagnosis Description:	1. 2.	ICD-10 Diagnosis Code:	1. 2.

Purpose of referral (check all that apply): ○ Rehab Therapy (PT/OT/ST) ○ Skilled nursing (IV meds/complex wound care, etc…) ○ Respiratory - Vent, Trach ○ Custodial, non-skilled services	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. ○ **Clinical Notes Attached**	Additional Comments:

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