Neighborhood Health Plan OF RHODE ISLAND™

Certificate of Medical Necessity
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 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 Request Sent:
Date of Service:	Previous Auth #:	Place of Service (City/Town)/Facility:
Provider Contact and Phone #:	Provider's Fax #:	Ordering MD:

CLINICAL INFORMATION			
CPT Code:	Units:	CPT Code:	Units:
Diagnosis:		Diagnosis Code:	

NOTE: For Absorbent Products (diapers), complete first page only.

Medical/ Surgical History Dates

______________________ ______________

______________________ ______________

______________________ ______________

Requested equipment (to include all accessories). May attach list.	Size	Quantity	Date of Service	Rent or Purchase
Duration of need _____ Months 1 year Indefinite Other				
Prognosis				

Indicate status of condition: Permanent Progressive Temporary, full recovery expected

Ordering practitioner signature ______________________ *Date*______________

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Is this equipment replacing a similar piece of equipment? Yes No

If yes, please justify ______________________________

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*List current equipment in member's home** | Rent or Purchased

______________________________ | ______________

______________________________ | ______________

______________________________ | ______________

______________________________ | ______________

*If this is new equipment, please detail why this equipment & accessories are medically needed.
PLEASE INCLUDE ANY AVAILABLE PICTURES, BROCHURES, SPECIFICATIONS.

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Place where equipment will be used home work school other

Has equipment been tried for accessibility and appropriateness? Yes No

If no, explain ______________________________

How will changes in height and weight affect this equipment? ______________________________

Current Schedule and Location of Therapies			
Physical Therapy	School based Daily	Outpatient Weekly	Early Intervention Monthly Other
Occupational Therapy	School based Daily	Outpatient Weekly	Early Intervention Monthly Other
Speech Therapy	School based Daily	Outpatient Weekly	Early Intervention Monthly 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