Neighborhood Health Plan OF RHODE ISLAND™



**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: | Provider 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** | |
|---|---|
| Diagnosis & Diagnosis Code: | **Test requested:**<br>❑ Full inhalant/respiratory panel<br>❑ Full food panel<br>❑ >1 food/inhalant panel in 12 months<br>❑ Total IgE<br>❑ Allergen specific IgE; qualitative, multiallergen screen (dipstick, paddle or disk) |
| Rationale for Test:<br>❑ Negative Single Specific IgE Test<br>❑ Negative Limited Panel Specific IgE Test<br>❑ Negative Skin Test 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** |