

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 | | |
| Rendering Provider's Name/Group Name: | Provider/Group 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 (Please include all supporting documentation) | | |
| Diagnosis & Diagnosis Code: | Procedure & Procedure Code: | |

By checking the box and signing below, you are attesting that these In Lieu of Services are an alternative to services which Neighborhood Health Plan of RI provides for members as medically appropriate therapy.

- Chiropractic Services in lieu of medications or invasive procedures for chronic pain.
- Acupuncture Services in lieu of medications or invasive procedures for chronic pain.
- Massage Therapy in lieu of medications or invasive procedures for chronic pain.

Authorization is not a guarantee of payment

| Signature of Treating Physician or Licensed Provider: | Date: | |
|---|--------------------|--|
| NEIGHBORHOOD DECISION | | |
| Authorization #: | Dates of Service: | Services Approved: |
| UM Initials: | Notification Date: | <input type="checkbox"/> Not Approved - Letter to Follow |