Neighborhood Health Plan OF RHODE ISLAND™

In Lieu of Service
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		
Rendering Provider's Name/Group Name: West Side Wellness	Provider/Group NPI#: 1417215690	Date Request Sent:
Date of Service: TBD	Previous Auth #:	Place of Service (City/Town)/Facility: Providence RI
Provider Contact and Phone #: 401-274-2225	Provider's Fax #: 401-274-2228	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:**	☐ **Not Approved - Letter to Follow**