

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](http://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 of Request:	
Date of Service:	Previous Auth #:	Place of Service (City/Town)/Facility:	
Provider's Phone #:	Provider's Fax #:	Provider's Contact Name:	
CLINICAL INFORMATION			
Inpatient Services <input type="checkbox"/> Outpatient Services <input type="checkbox"/>			
CPT Code:	Units:	CPT Code:	Units:
Diagnosis:		Diagnosis Code:	
Current BMI:	Height:	Weight:	
Describe impact on Activities of Daily Living:			
Describe co-morbid or other health conditions:			
Describe medically supervised weight loss attempts in last 6 months:			
Comment on demonstrated ability to comply with medical regimen:			
List any current psychiatric/psychosocial co-morbidities & treatment in place:			
Comment on ability to understand risk of gastric bypass surgery:			
NOTE: THIS FORM MUST BE SIGNED BY A PHYSICIAN			
Signature of Treating Physician:		Date:	
NEIGHBORHOOD DECISION			
<i>Authorization is not a guarantee of payment.</i>			
Authorization #:	Dates of Service:	Services Approved:	
UM Initials:	Notification Date:	<input type="checkbox"/> Not Approved - Letter to Follow	