

PRE-CERTIFICATION FORM

NEIGHBORHOOD HEALTH PARTNERSHIP

Fax Non-Urgent Requests to 800-731-2515.

• Please be advised, failure to comply with Utilization Management certification protocol will result in non-payment of your claim. **To avoid any delay of this review, please submit all relevant documentation with this form (dictation, progress notes, consultation requests and results).**

• **Verification of benefits, eligibility, or authorization of a service is not a guarantee of payment. Payment remains subject to all of the terms and conditions of the member's benefit plan, including exclusions and limitations. If this member's coverage has pre-existing condition exclusion, payment will be subject to a pre-existing condition investigation at the time claims are filed.**

This form must only be used for Routine Requests. All Medically Urgent requests must be called in to the NHP Utilization Management at the numbers listed below.

Requests for **MEDICALLY URGENT** services: call NHP Utilization Management Department at: 800-550-5568.

The definition of Medically Urgent is: any request for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

- could seriously jeopardize the life or health of the member or the member's ability to regain maximum function based on a prudent layperson's judgment or
- In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

Patient Information	Requesting Provider Information
Patient Name: _____	Provider Name: _____
ID Number: _____	Provider ID: _____
Patient DOB: ____/____/____	Phone: _____ Fax: _____
	Contact Name: _____
	<input type="checkbox"/> PCP Request
Services requested – Supporting documentation must be sent with each request.	
Date of service: ____/____/____	Place of Service (facility): _____

Referral Information	
<input type="checkbox"/> CT scan of _____	<input type="checkbox"/> Pain Management
<input type="checkbox"/> MRI of _____	<input type="checkbox"/> Prosthetics / Orthotics
<input type="checkbox"/> MRA of _____	<input type="checkbox"/> Transfusion / Infusion Inpatient admission
<input type="checkbox"/> PET Scan of _____	<input type="checkbox"/> Ambulatory Outpatient surgery
<input type="checkbox"/> Sleep Studies	<input type="checkbox"/> Infusion
<input type="checkbox"/> Nuclear Stress Test	<input type="checkbox"/> Drug Name: _____
<input type="checkbox"/> Invasive vascular studies / ED studies	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Dialysis	_____
Procedure Information	
Procedure(s): _____	Primary Diagnosis: _____
_____	Secondary Diagnosis: _____
_____	Diagnosis Code: _____
