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: ☐ Full inhalant/respiratory panel ☐ Full food panel ☐ >1 food/inhalant panel in 12 months ☐ Total IgE ☐ Allergen specific IgE; qualitative, multiallergen screen (dipstick, paddle or disk)
Rationale for Test: ☐ Negative Single Specific IgE Test ☐ Negative Limited Panel Specific IgE Test ☐ Negative Skin Test ☐ Other: ______________________	
NOTE: THIS FORM MUST BE SIGNED BY A PHYSICIAN	
Signature of Treating Physician:	**Date:**

NEIGHBORHOOD DECISION		
Authorization #:	Dates of Service:	Services Approved:
UM Initials:	**Notification Date:**	☐ **Not Approved - Letter to Follow**