Procedures & Admissions Pre-certification/Pre-authorization Request Form

Neighborhood Health Plan, 253 Summer Street, Boston, MA 02210
Phone: 855-444-4NHP | Fax: 617-772-5512

Facility & Physician Billing Information

Rendering Facility Name		Rendering Facility Group NPI	
Name of Person Completing This Form	Date Form Completed	Phone	Fax
Rendering Physician Group Name	Rendering Physician Group NPI (if different from above)	Date of Admission	Estimated Discharge Date

Patient Information

Patient Name	Patient ID Number	Check One: ☐ Male ☐ Female	Date of Birth
Patient Address		Patient Phone Number	
Primary Care Provider		Patient Hospital Medical Record Number	

Service Type (Circle One)

Ambulatory Surgical Procedure (Outpatient)	Medical Admission ☐ Emergent ☐ Elective	Transplant
Observation Services		
Other ______________________________	Obstetrical Admission (Inpatient)	Surgical Admission (Inpatient)

Diagnostic Information

Principal Diagnosis (Description & ICD-9 Code)	Principal Procedure (Description & CPT Code)
Secondary Diagnosis (Description & IC D-9 Code)	Secondary Procedure (Description & CPT Code)
Clinical Indications for Admission and/or Procedure (signs, symptoms & test results)	
Is supporting medical necessity documentation being submitted with this form? ☐ No ☐ Yes. Number of pages attached: ____________	

For Health Plan Use Only

Care Manager's Name	Care Manager's Phone Number
Referral Status (Check One): ☐ Approved ☐ Denied ☐ Pended	