Request to Review/Create a Clinical Medical Policy/Request for Coverage

Please complete this form and return
Via Email: amdfacsimiles@nhpri.org
Or via Fax: 401-709-7119
Attention: Utilization Management Committee

Name _____ **Title/Position**_____ Contact Number_____

Today's Date: _____

Type of Action Requested – Please check one:

- ☐ New clinical medical policy
- ☐ Request to modify existing clinical medical policy
- ☐ Add Coverage for Sevice or Product

CMP Name: _____

New: Describe the clinical policy requirement/request for coverage you have identified and reference the literature or other documented standards of practice that you believe should be utilized to develop the policy. Please attach references if available.

_____

Request to Modify: Describe your recommended modification(s) and reference the literature or other documented standards of practice that you believe should be utilized to develop the policy. Please attach references if available.

_____

For Neighborhood Use Only:
Date CMP Last Reviewed if Existing CMP: _____**Next Scheduled Review Date:** _____