## Prior Authorization Request Form

**For Medical Procedures**

### MEMBER INFORMATION

<table>
<thead>
<tr>
<th>Name:</th>
<th>Gender (Circle One):</th>
<th>M</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOB:</td>
<td>Other Insurance:</td>
<td></td>
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</tr>
<tr>
<td>Member ID:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### PROVIDER INFORMATION

<table>
<thead>
<tr>
<th>Name:</th>
<th>NPI:</th>
<th>Tel:</th>
<th>Specialty:</th>
<th>Fax:</th>
<th>Address:</th>
<th>Contact Person:</th>
</tr>
</thead>
</table>

### REQUIRED CLINICAL INFORMATION

**Diagnoses (List ICD-10 Codes and Description)**

1)  
2)  
3)  
4)  

**Additional:**

**Procedure(s) Requested (List all CPT/HCPCS Codes and Descriptions)**

1)  
2)  
3)  
4)  
5)  
6)  

**Date of Service:**

Please attach supporting clinical information, which should include if available:

- Medical Records
- Lab Reports
- Progress Notes
- Diagnostic Studies
- Referrals
- Plan of Care

**Please note:** Determination of medical necessity will be made within three business days of receiving this form and all necessary information. There may be a delay if additional information is needed.

**Completed form and all supporting documentation may be submitted to CHP via fax or email:**

Fax: 413-781-1958  
Email: priorauth@chpemail.com