CHP Consolidated Health Plans
A Berkshire Hathaway Company

Prior Authorization Request Form

For Prescription Medications- Submit only <u>after</u> receiving a pharmacy rejection.

MEMBER INFORMATION	
Name:	Gender (Circle One): M F
DOB:	Other Insurance:
Member ID:	

PROVIDER INFORMATION	
Name:	NPI:
Tel:	Specialty:
Fax:	Address:
Contact Person:	

PRESCRIPTION AND CLINICAL INFORMATION
1)Date RX Written:
2)Drug Name/Strength:
3)Dosage Form:
4)Quantity:
5)Directions:
6)Diagnosis:
7)Generic Substitution Allowed?
8)Refills:
9)Additional Comments:

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

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

<u>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.</u>

Completed form and all supporting documentation may be submitted to CHP via fax or email:
Fax: 413-781-1958 Email: priorauth@chpemail.com

Note: For MA plans, providers may alternatively submit "Massachusetts Standard Form for Medication Prior Authorization Requests" developed by the Massachusetts Collaborative and available on www.consolidatedhealthplan.com.