

MEMBER INFORMATION           Member's Name:         Member's ID Number:         Member's DOB:           REQUESTING PROVIDER INFORMATION         Provider's Phone #:         Provider's Fax #:           Provider's Name:         Provider's Phone #:         Provider's Fax #:           Provider's Name:         Provider's Contact Name and Phone #:         Provider's Fax #:           Provider's NPI #:         Provider's Contact Name and Phone #:         SERVICING PROVIDER INFORMATION (Must be filled out appropriately to ensure claim adjudication)           HOW WILL MEDICATION BE OBTAINED:         NPI:	Please complete the form by providing all of the following information. Failure to fill out this form in its entirety may delay the review process. To review the Clinical Medical Policies, please visit our website at https://www.nhpri.org/Providers/ClinicalMedicalPolicies.aspx			
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guidelines, authorization policies, provider contract agreements, and state and federal regulations.