NORTHERN NEW ENGLAND BENEFIT TRUST
P.O. BOX 4604 MANCHESTER NH 03108
PHONE: 800-258-9732; 603-669-4771 FAX: 603-666-4477

NORTHERN NEW ENGLAND BENEFIT TRUST
PRESCRIPTION COVERAGE REQUEST FORM

PHYSICIAN INFORMATION	PATIENT INFORMATION
NAME:	PATIENT NAME:
PCP:	MEMBER ID #:
SPECIALTY IF APPLICABLE:	
OFFICE CONTACT:	
ADDRESS:	BIRTH DATE:
	ADDRESS:
PHONE:	
FAX:	PHONE:

DRUG REQUESTED:	DOSAGE:	STRENGTH:
IF REQUESTING A PPI, PLEASE INDICATE UPPER G.I. SERIES TEST RESULTS		
DIAGNOSIS (RELATED TO USE):	EXPECTED DURATION OF THERAPY:	

PREVIOUS MEDICATIONS:	LENGTH OF TREATMENT:	REASON FOR FAILURE:

PHYSICIAN SIGNATURE:	DATE:

FAX COMPLETED FORM TO: 603-666-4477 ATTENTION BRENDA ALBIN

PATIENT WILL BE CONTACTED DIRECTLY WITH THE MEDICAL CONSULTANT'S DECISION.

March, 2003