BlueAdvantage Administrators of Arkansas

An Independent Licensee of the Blue Cross and Blue Shield Association

Please fax or mail responses to:
BlueAdvantage Administrators of Arkansas
PO Box 1460
Little Rock, AR 72203-1460
Fax: 501-301-1958

WALMART OUT OF NETWORK PROVIDER EXCEPTION REQUEST FORM

DATE REQUEST SUBMITTED:		
SECTION 1 - REQUESTER INFORMATION		
Doctor/Facility Name:		
Address:		Suite/Building:
City:	State:	ZIP Code:
Phone #:	Fax #:	Contact Person:
SECTION 2 - PATIENT INFORMATION		
Patient Name:	Plan ID #:(include Alpha Prefix)	
Address:	Apt #/Building:	DOB:
City:	State:	ZIP Code:
Policy Holders Name:		
NOTE- FOR SECTION 3 AND 4 **IF REQUEST IS FOR OUT-OF-NETWORK PHYSICIAN/SURGEON – COMPLETE SECTION 3 ONLY** **IF REQUEST IS FOR AN OUT-OF NETWORK FACILITY – COMPLETE SECTION 4 ONLY** **IF REQUEST IF FOR AN OUT-OF-NETWORK PHYSICIAN/SURGEON AND FACILITY – COMPLETE SECTIONS 3 & 4**		
SECTION 3 – PHYSICIAN/SURGERY (OON)		
Name of Physician or Surgeon:		
Address:	Suite/Building:	
City:	State:	ZIP Code:
Phone #:	Fax #:	
SECTION 4 – FACILITY (OON)		
Name of Facility:		
Address:	Suite/Building:	
City:	State:	Zip Code:
Phone #:	Fax #:	
SECTION 5 - MEDICAL INFORMATION		
Diagnosis Codes: (ICD 10)		
CPT 4 Codes:		
HCPC Codes:		
Treatment Plan: (If necessary use additional pages)		
Please indicate reason for patient seeking treatment from an out-of-network provider:		

Please note – This form does not constitute that an exception has been allowed, unless you receive written confirmation from BlueAdvantage Administrators. Failure to obtain an approval may result in a reduction of payment based on the plan benefit.

Network Exceptions will only be considered when complete medical information and a treatment plan are submitted with this request. Please submit any supporting documentation that would be of assistance for this request.

8/16/2016