



# 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)210-7051

*Please allow 72 hours for review and acknowledgement of initial receipt.  
Responses are mailed and/or faxed if a fax number is provided.*

## BLUE ADVANTAGE PRIOR APPROVAL REVIEW FORM FOR MEDICATIONS

DATE REQUEST SUBMITTED:

### SECTION 1 - REQUESTER INFORMATION

Doctor/Facility Name:		Tax ID or NPI#:	
Network Status:			
Address:		Suite/Building:	
City:	State:	ZIP Code:	
Phone #:	Fax #:	Contact Person:	

### SECTION 2 - PATIENT INFORMATION

Patient Name:		Member ID #:(include Alpha Prefix)	
Address:		Apt#/Building:	DOB:
City:	State:	ZIP Code:	
Policy Holders Name:		Plan/Group Name:	

*Please Note: Sections 3-5 are for the performing/rendering providers' information.*

### SECTION 3 – RENDERING PROVIDER (NON-FACILITY)

Provider Name		Tax ID or NPI#:	
Provider Specialty:			
Address:		Suite/Building:	
City:	State:	ZIP Code:	
Phone #:		Fax #:	

### SECTION 4 – RENDERING FACILITY (IF APPLICABLE)

Name of Facility:		Tax ID or NPI#:	
Address:		Suite/Building:	
City:	State:	Zip Code:	
Phone #:		Fax #:	

### SECTION 5 – SERVICE INFORMATION

Scheduled Service Date:	Repeat Service (Y or N)
J Code:	Dosage/Units:
NDC#:	Diagnosis Codes (ICD 10):

Medical Reason:

Please Attach Medical Records, Treatment Plan, and any other Documentation Supporting the Medical Reason Indicated Above. \*\*\*

**\*\*\*NOTE\*\*\* A Prior Approval will only be considered when complete medical records and a treatment plan or letter of medical necessity are submitted with this request. Please submit any supporting documentation that would be of assistance for this request.**