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: 501-378-3399

Please allow 7-10 business days for review and response.
Responses are mailed and/or faxed if a fax number is provided.

BLUE ADVANTAGE PRIOR APPROVAL REVIEW FORM

DATE REQUEST SUBMITTED:		
SECTION 1 - REQUESTER INFORMATION		
Doctor/Facility Name:	Tax ID or NPI#:	
Network Status:		
Address:		
City:	State:	ZIP Code:
Phone #:	Fax #:	Contact Person:
SECTION 2 - PATIENT INFORMATION		
Patient Name:	Plan ID #:(include Alpha Prefix)	
Address:		DOB:
City:	State:	ZIP Code:
Policy Holders Name:		
Please Note: Sections 3-5 are for the performing/rendering providers' information.		
SECTION 3 – RENDERING (NON-FACILITY) PROVIDER		
Provider Name	Tax ID or NPI#:	
Provider Specialty:		
Address:		
City:	State:	ZIP Code:
Phone #:	Fax #:	
SECTION 4 – RENDERING FACILITY (IF APPLICABLE)		
Name of Facility:		
Address:		
City:	State:	Zip Code:
Phone #:	Fax #:	
SECTION 5 – SERVICE INFORMATION		
Scheduled Service Date:	Repeat Service (Y or N)	
CPT 4 Codes or HCPC Codes:		
Diagnosis Codes (ICD 10)		
If DME – indicate expected duration:		
Does the patient need additional visits or days for Occupational Therapy, Physical Therapy, Speech Therapy, Skilled Nursing Facility, Long-term Acute Care or Hospice? (Y or N)		
Please Attach Medical Records, Treatment Plan, and any other Supporting Documentation.		

******NOTE*** A Prior Authorization 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.***

Form Version Date: 7/24/17