



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 BENEFIT INQUIRY 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