

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

SECTION 1 - REQUESTER INFORMATION Tax ID or NPI#: Tax ID or NPI#: Suite/Building: Suite/Building: Address: Suite/Building: CIP Code: Patient Name: Suite/Building: Contact Person: Patient Name: Member ID #: (include Address: Apt#/Building: DOB: Contact Person: Patient Name: Member ID #: (include Address: Apt#/Building: Contact Person: Patient Name: Member ID #: (include Address: Patient Name: Member ID #: (include Address: Patient Name: DOB: Provider Sections 3 - RENDERING VOUDER (NON-FACUER' NON-FACUER' Sections - RENDERING VOUDER (NON-FACUER' Sections - RENDERING VOUDER (NON-FACUER' Sections - RENDERING VOUDER (NON PI#: Provider Spacially: ZIP Code: Sute/Building: CIP Code: Patie VETON S - RENDERING VOUDER (NON PI#: <th colspa<="" th=""><th colspan="6">DATE REQUEST SUBMITTED:</th></th>	<th colspan="6">DATE REQUEST SUBMITTED:</th>	DATE REQUEST SUBMITTED:					
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	Medical Reason:						

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