

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:					
Network Status:       Sute/Building:         Address:       State:       ZIP Code:         Pione #:       Fax #:       Contact Person:         Patient Name:       Member ID #: (include Alpha Prefix)       Address:         Address:       Apt#/Building:       DDB:         City:       Apt#/Building:       ZIP Code:         Policy Holders Name:       Par/Group Name:       ZIP Code:         Please Note: Sections >= are for the person:         Section	SECTION 1 - REQUESTER INFORMATION						
Address:     Suite/Building:       City:     State:     ZIP Code:       Phone #:     Fax #:     Contact Person:       Member ID #: (Inclus Alpha Person:       Member ID #: (Inclus Alpha Person:       Address:       Address:       Address:       Address:       Please Note: Sections 3- are for the person/Person/Person/Person       Please Note: Sections 3- are for the person/Person/Person/Person/Person       Please Note: Sections 3- are for the person/Pers	Doctor/Facility Name:		Tax ID or NPI#:				
City:     State:     ZIP Code:       Phone #:     Fax #:     Contac Person:       Contact INFORMATION       SECTION 2 - PATIENT INFORMATION       Patient Name:     Member ID #: (Include Alpha Pirsfix)       Address:     Apt#/Building:     DOB:       City:     Apt#/Building:       Please Note: Sections 3-5 are for the pertormalion providers Information.       Please Note: Sections 3-5 are for the pertormalion providers (NON-FACLITY)       Please Note: Sections 3 - RENDERING PROVIDER (NON-FACLITY)       Tax ID or NPI#:       Provider Sactions 3 - RENDERING PROVIDER (NON-FACLITY)       Provider Sections 3 - RENDERING PROVIDER (NON-FACLITY)       Yourig: Sections 3 - RENDERING PROVIDER (NON-FACLITY)       Yourig: Sections 3 - RENDERING PROVIDER (NON-FACLITY)       Yourig: State:       Yourig: State:       Yourig: State:       Section V - RENDERING PROVIDER       Yourig: State:       Section S - Section S - Section S - Section Site Provider (Yor N)       Section S - Section Site Provider (Yor N)       Section Site Provider (Yor N)       Section Site Provider (Yor N)       Sechedual Reason:	Network Status:						
Pane#:       Fax #:       Contact Person:         Contact Person:         Patient Name:       Member 10 #: (Include Alpha Perfix)         Address:       Apt#/Building:       DOB:         City:       State:       ZIP Code:         Pointer Konter Sections 3 = Fendering performation         Provider Name:       Pan/Group Name:         Provider Sections 3 = Fendering performation         SECTION 2 = RENDERING (NON-FACLITY)         Provider Specialty:         Address:         State:       Tax ID or NPI#:         Provider Specialty:         Address:       State:       ZIP Code:         Provider Specialty:         Address:       State:       ZIP Code:         Provider Specialty:         Address:       State:       ZIP Code:         State:       State:       ZIP Code:         Provider Facility:         Address:       Suite/Building:         Colspan="2">Colspan="2">Colspan="2">Colspan="2">Colspan="2">Colspan="2">Colspan="2">Colspan="2">Colspan="2">Colspan="2">Colspan="2">Colspan="2">Colspan="2">Colspan="2"         State:       <	Address:		Suite/Building:				
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Patient Name:       Member ID #: (include Alpha Prefix)         Address:       Apt#/Building:       DOB:         City:       State:       ZIP Code:         Policy Holders Name:       Plan/Group Name:       ZIP Code:         Plan/Group Name:         Plan/Group Name:         Plan/Group Name:         Planes Note: Sections - RENDERING PROVIDER (NON-FACILITY INFORMATION.         Section 3 – RENDERING PROVIDER (NON-FACILITY INFORMATION.         Provider Specialty:         Address:         State:         Verovider Specialty:         Address:         State:         Section Sectin Section Section Sectin Section Section Sectin Section Section	Phone #:	Fax #:	Fax #:		Contact Person:		
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SECTION 3 - RENDERING VOULER (NON-FACINGProvider NameTax ID or NPI#:Provider Specialty:Suite/Building:Address:State:ZIP Code:City:State:ZIP Code:Phone #:Fax #:SECTION 5 - SERVERING VENDIALName of Facility:State:Tax ID or NPI#:Address:Suite/Building:City:State:Tax ID or NPI#:Address:Suite/Building:City:State:Zip Code:Phone #:State:Zip Code:Phone #:Fax #:Scheduled Service Date:Repeat Service (Y or NScheduled Service Date:NDC#:Dosage/Units:NDC#:Diagnosis Codes (IC Di):Medical Reason:State:State:Please Attach Medical Records, Treatment Plan, and any terr Documentation Supporting the Medical Reason	Policy Holders Name: Plan/Group Name:						
Provider Name       Tax ID or NPI#:         Provider Specialty:       Suite/Building:         Address:       Suite/Building:         City:       State:       ZIP Code:         Phone #:       Fax #:         SECTION 4 – RENDERING CITY (IF APPLICE/SUPCIDE)         Name of Facility:       A # :         Address:         Site/Building:         City:       State:       Zip Code:         Phone #:       Site/Building:       Zip Code:         City:       State:       Zip Code:         Phone #:       Fax #:       State:         Scheduled Service Date:         Posage/Units:         Scheduled Service Date:         NDC#:       Dosage/Units:         NDC#:       Diagnosis Codes (ICU ):       Medical Reason:         Please Attach Medical Records, Treatment Plan, and any ther Documentation Supporting the Medical Reason	Please Note: Sections 3-5 are for the performing/rendering providers' information.						
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Name of Facility:Tax ID or NPI#:Address:Suite/Building:City:State:Zip Code:Phone #:Fax #:SECTION 5 – SERVUCE INFORMATIONScheduled Service Date:Repeat Service (Y 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	Phone #:		Fax #:				
Address:       Suite/Building:         City:       State:       Zip Code:         Phone #:       Fax #:         SECTION 5 – SERVE INFORMATION         Section 5 – SERVE INFORMATION         Scheduled Service Date:         J Code:       Repeat Service (Y or N)         J Code:       Dosage/Units:         NDC#:       Diagnosis Codes (IC J 10):         Medical Reason:       Please Attach Medical Records, Treatment Plan, and any other Documentation Supporting the Medical Reason	SECTION 4 – RENDERING FACILITY (IF APPLICABLE)						
City:       State:       Zip Code:         Phone #:       Fax #:       SECTION 5 - SERVICE INFORMATION         Scheduled Service Date:       Repeat Service (Y or N)       Dosage/Units:         J Code:       Dosage/Units:       Diagnosis Codes (ICD 10):         Medical Reason:       Please Attach Medical Records, Treatment Plan, and any other Documentation Supporting the Medical Reason	Name of Facility:		Tax ID or NPI#:				
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Please Attach Medical Records, Treatment Plan, and any other Documentation Supporting the Medical Reason	NDC#:		Diagnosis Codes (ICD 10):				
	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.