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.***

01/03/2018