Prior Approval Request Form

Note: Please submit 5-7 business days prior to the scheduled date of service to allow adequate time for request and receipt of information needed to process the request. Once all information is received, requests are generally reviewed within 2 business days.

Date request submitted: _____

Section 1 - Requester information (please print or type)

Doctor/Facility name	Tax ID number	NPI number	Network status

Address	City	State	ZIP

Phone number	Fax number	Contact person

Section 2 - Patient information (please print ot type)

Patient first name	M.I.	Last name	Patient DOB (mm/dd/yyyy)

Patient address	City	State	ZIP

Policyholder name	Plan ID number (include Alpha Prefix)

Please Note: Sections 3-5 are for the performing/rendering providers' information.

Section 3 – Rendering (non-facility) provider (please print or type)

Provider name	Tax ID #	NPI #	Specialty

Address	City	State	ZIP

Phone	Fax

Section 4 – Rendering facility (if applicable) (please print or type)

Name of facility

Address	City	State	ZIP

Phone	Fax

Section 5 – service information (please print or type)

Name of facility	Repeat service ☐ Yes ☐ No	Service date(s)

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?

☐ Yes ☐ No

Please Attach Medical Records, Treatment Plan,
and any Relevant Clinical Documentation to support the request.

Please fax or mail responses to:
BlueAdvantage Administrators of Arkansas
PO Box 1460
Little Rock, AR 72203-1460

or

Fax: 501-378-3399

Forms that are illegible or incomplete will not be processed.
Responses will be faxed if a valid fax number is provided, otherwise responses will be mailed.