Prior Approval Request Form

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.