BlueAdvantage Administrators of Arkansas
An Independent Licensee of the Blue Cross and Blue Shield Association

DATE: _____

NAME: _____ BLUE ADVANTAGE ID #: _____

GROUP NAME: _____ CITY_____ STATE _____
Coverage & eligibility verified by: _____ Extension: _____

Please check one:
PPO EXCEPTION ___ TRANSPLANT REQUEST ___ PHARMACEUTICAL ___
_____
_____

PATIENT NAME:_____ DATE OF BIRTH_____
ADDRESS _____
CITY _____ STATE____ ZIP _____ COUNTY_____

NOTE: NETWORK EXCEPTIONS WILL BE CONSIDERED ONLY WHEN COMPLETE MEDICAL INFORMATION AND TREATMENT PLAN IS SUBMITTED.

EXCEPTION REQUEST FOR:
HOSPITAL NAME_____ DATE OF SERVICE_____
PHYSICAN NAME_____DATE OF SERVICE_____
DRUG NAME _____
OTHER_____

MEDICAL CONDITION: PLEASE HAVE YOUR PHYSICIAN COMPLETE
DIAGNOSIS _____
TREATMENT _____
MEDICAL NECESSITY FOR SEEKING TREATMENT OUT OF PPO NETWORK:

_____
WAS THIS PATIENT REFERRED OUT OF NETWORK BY A PPO PROVIDER?____
IF YES, PLEASE INDICATE NAME AND ADDRESS_____
IS THIS EPISODE OF CARE, PHYSICIAN CHOICE_____
PATIENT CHOICE_____ EMERGENCY_____

If additional space is needed to complete this form, please use additional paper and attach To this form. Also attach any medical records that support this request. Thank you.

FORM COMPLETED BY_____ TELEPHONE # _____