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: 501-301-1936

Please allow 7-10 business days for review and response.
Responses are mailed and/or faxed if a fax number is provided.

WALMART COURTESY REVIEW FORM

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:	Plan ID #:(include Alpha Prefix)	
Address:	Apt#/Building:	DOB:
City:	State:	ZIP Code:
Policy Holders Name:		

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

SECTION 3 – RENDERING (NON-FACILITY) PROVIDER

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:		
Address:		Suite/Building:
City:	State:	Zip Code:
Phone #:		Fax #:

SECTION 5 – SERVICE INFORMATION

Scheduled Service Date:	Repeat Service (Y or N)
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? (Y or N)	
Please Attach Medical Records, Treatment Plan, and any other Supporting Documentation.	

****NOTE*** A Courtesy Review 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.*

8/16/2016