Prior Approval Request Form | Outpatient/Clinic Services

Form **not applicable** for BlueAdvantage members

This form may **ONLY** be utilized to submit a request for a service that requires prior approval.

PLEASE PROVIDE ALL RELEVANT CLINICAL DOCUMENTATION TO SUPPORT REQUEST.

Any person who knowingly submits this form containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

PLEASE PRINT OR TYPE THE INFORMATION REQUESTED

Forms that are not legible or incomplete will not be processed.

Provider information

Name of provider submitting request	**Individual physician NPI**	**Clinic NPI**

Address	**City**	**State**	**ZIP**

Referring provider name	**Referring provider NPI**

Name of person completing form (information will be returned to this person)

Phone	**Fax**	**Email**

Scheduled service date	**Place of service**

Please note: Request should be submitted 5-7 business days prior to the scheduled date of service in order to allow adequate time for request and receipt of information needed to process the request. Once all requested information is received, requests are generally reviewed within 2 business days.

Patient information

Last name	**First name**	**ID number**

Birth date	**Gender**	**Patient relationship to subscriber**

Address	**City**	**State**	**ZIP**

Pre-service information

Medical reason

Diagnosis Code - At least one must be listed or all that apply

Primary diagnosis description	**Place of service**

Additional diagnosis codes

Procedure Code (CPT/HCPCS) - At least one must be listed or all that apply

Specific units requested for each code must be provided or request will not be processed. When Requesting medications, specify if the provider is to buy and bill, For J codes, the NDC # along with the date span, dosages and/or number of units are required.

CPT Code	Modifiers	NDC number	Minutes/Units/Dosage	Diagnosis pointer
Primary:				
Secondary:				
Other:				
Other:				
Other:				
Other:				
Other:				

Other information including RX information

DISCLAIMER: Information provided is as of the date of the reply and member information that has been processed. If patient eligibility, benefits, coverage limits, exclusions changes (please check for current patient information on AHIN) or if post claims information does not match this prior approval service request information the approval is not valid. Additional visits or services occurring after the reply date might exceed the limits of the contract or policy and would accordingly not be covered under the contract or policy.

Return completed form by mail:
Arkansas Blue Cross and Blue Shield
Attention: Medical Audit and Review Services
P.O. Box 2181
Little Rock, AR 72203
by fax: 501-378-6647

Responses will be faxed if a valid fax number is provided, otherwise responses will be mailed.