Exception letter

Date: _____

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.

Name	BlueAdvantage Administrators of Arkansas 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
Physician 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? ☐ Yes (If yes, please indicate name and address) ☐ No

Provider name

Street or PO box	City	State	ZIP	County

Is this episode of care, ☐ Physician choice ☐ Patient choice ☐ Emergency

Form completed by	Phone

The request must be mailed or faxed to: BlueAdvantage Administrators of Arkansas, Attn: Customer Service, PO Box 1460, Little Rock, AR 72203 or Fax: 501-301-1989