BlueAdvantage Administrators of Arkansas

An Independent Licensee of the Blue Cross and Blue Shield Association

Primary Care Network (PCN) Referral Authorization Form

Please fax a copy of this referral authorization form to BlueAdvantage at **(501) 378-6669**.

Attention Member: This form authorizes the following specialist to forward medical information to your Primary Care Physician to assist with coordination and continuity of your care.

Member Name: _____ ID#: _____

Specialist: _____

Diagnosis(es): _____

Reason for Referral: _____

Restrictions: _____

Other: _____

Date Span: _____ to _____ Number of Visits: _____

_____ _____ _____

PCP Name (Please Print) Signature Date

ABCBS 5-digit Provider Number: ☐ ☐ ☐ ☐ ☐

National Provider Identifier Number: _____

Important Information for the Physician and Member

Referral services are subject to member eligibility and the benefits available through the member's plan; therefore, this referral should not be considered a guarantee of payment.

Primary Care Physician/Member:

Out-of-Network referrals require prior notification. Services referred to or provided by an OON provider may not be eligible for reimbursement or may be covered at a reduced benefit level.

If more information about this process is needed, or to verify eligibility and benefits, please call the customer service number on the member ID card. Please have the card ready when you call. You may also contact your local Regional Office.

Specialist:

Please contact the PCP if additional referrals are recommended.

X-ray and lab results may be available. To avoid duplication, please check with the PCP.

Indicate either the BCBS provider # or the NPI # in field 23 on HCFA 1500 claim form.