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

WALMART COURTESY REVIEW REQUEST FORM

PLEASE FAX TO **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.

(*This from does not constitute that a service has been approved unless you receive a written confirmation from BlueAdvantage Administrators*)

Date: _____ Tax ID or NPI #:_____

Name of the provider submitting request: _____

Address: _____City _____ _____ State_____ Zip _____

Name of the rendering provider: _____

Address: _____City _____ _____ State_____ Zip _____

Name of person completing this form: _____

Contact Telephone Number: _____ FAX Number: _____

Member ID #: _____ Call Reference #:_____

Patient Name: _____

Scheduled Service Date: _____ Repeat Service: Y or N_____

Procedure code: (CPT4 or HCPCS):_____

Diagnosis codes (ICD9):_____

If DME expected duration: _____

Please Attach Medical Records

NOTE *Courtesy Review will be considered when **complete medical records** and a **treatment plan** or **letter of medical necessity** are submitted with this request. Please submit any records or correspondence that would be helpful.*