Medicare Advantage single case agreement form

Instructions: Providers must first obtain a medical necessity approval for services, prior to requesting a Single Case Agreement (SCA). Please fill out all applicable sections on both pages completely and legibly before faxing or mailing the form to the number or address listed below. Attach any additional documentation necessary for processing the SCA. Information contained in this form is Protected Health Information under HIPAA.

Please Note: This form does not constitute a rate agreement, a fully executed agreement from Arkansas Blue Medicare must be in place prior to service delivery. Failure to return the signed LOA form with approval signatures from your agency may result in a reduction or denial of payment based on the benefit plan.

1. Medicare assignment

Does provider/facility accept Medicare assignment? ☐ Yes ☐ No

2. Medical necessity approval

Approved authorization number _____ *Required

3. Member information

First name	**Middle initial** (M.I.)	**Last name**
Phone number	**Patient DOB** (mm/dd/yyyy)	**Member ID #** (including prefix)

Member address	**City**	**State**	**ZIP**

4. Servicing provider

Provider name	**Tax ID #**	**NPI #**	**Specialty**	**Contact name**

Group name	**Phone**	**Fax**

Group address	**City**	**State**	**ZIP**

Email	**DEA #** (if applicable)

5. Servicing clinic/facility

Provider name	**Tax ID #**	**NPI #**	**Specialty**	**Contact name**

Group/facility name	**Phone**	**Fax**

Group address	**City**	**State**	**ZIP**

Email	**DEA #** (if applicable)

6. Additional treating providers

Provider name	Tax ID #	NPI #	Specialty	Contact name

Group name	Phone	Fax

Group address	City	State	ZIP

Email	DEA # (if applicable)

7. Coding

ICD-10 code(s)	ICD-10 description

HCPCS/CPT/CDT code	Code description	Medical reason	Start date	End date	Frequency requested

8. Additional comments

7. Attest and sign

By signing below I confirm that the information provided is accurate to the extent of my knowledge. Additionally, I acknowledge this request form does not guarantee approval or reimbursement and a fully executed agreement must be in place prior to service delivery.

Requester signature

Date signed (mm/dd/yyyy)

Please return this signed form to:
Arkansas Blue Medicare
ATTN: 10th Fl MA Single Case Agreement
320 W Capitol
Little Rock, AR 72202

or

Fax:
1-816-313-3014