Arkansas BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

*Organization Determination/*Prior Authorization Form

Forms should be faxed to 1-877-482-9749

Date / /

Member Information

Member Name_____ Member ID_____		
Member Address (Street, City, State, ZIP)		
Member Phone	Member Gender F/M	Member DOB ___/___/_____

Physician Information

Treating Physician Name_____

☐ **Please check here if you are submitting this Organizational Determination/Prior Authorization Form on behalf of and with Member/Patient's knowledge and consent.**

Address (Street, City, State, ZIP)	
Telephone Number Office ( )	Fax Number Office ( )
Contact Name	Provider Number

Diagnosis and Medical Information

Service Description	Procedure Code	Diagnosis Code	Place of service
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Physician Signature: _____ Date: _____

*Prior Authorization is required on Medi-Pak HMO only for inpatient and skilled nursing facilities.

*Organization Determination requests are to determine if a specific service is covered.