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

Fax (501) 378-6647
Attention: Medical Review Division

Network Exception Form

Note: Network Exceptions will be considered only when complete medical information and treatment plans are submitted.

Date Request Submitted:_____

Member(Patient's) Name: _____Member ID_____

Member (Patient's) Date of Birth: _____Group Name _____Group ID # _____

Coverage & Eligibility verified by: _____Extension:_____

Please check one: Network Exception • Transplant Request • Pharmaceutical •

Insureds Name (if different from patient)_____Date of Birth: _____

Address: _____

City:_____State:_____Zip Code:_____

EXCEPTION REQUEST FOR

Facility/Hospital Name: _____Date of Service: _____

Address: _____

Phone #: _____Fax #:_____

Physician Name: _____Date of Service: _____

Address: _____

Phone #:_____Fax #:_____

Drug Name: _____

Other (lab, x-ray, etc.):_____

MEDICAL CONDITION: THIS AREA TO BE COMPLETED BY PHYSICIAN

Diagnosis:_____

Treatment:_____

Medical Necessity for seeking treatment out of network:

_____

_____

_____

Name of Physician Completing form: _____

Physician Address:_____

Physicians phone number: _____ Physicians fax number: _____

Physician Signature:_____

Are you the patient's PCP? Yes or No FirstSource Provider? Yes or No Health Advantage Physician? Yes or No

Is this episode of care: Physician Choice • Patient Choice • Emergency •

Form may be faxed to #501-378-6647, Attn: Medical Review Division or mailed to

Arkansas BlueCross and BlueShield, Attn: Medical Review Division at PO Box 2181, Little Rock, AR 72203-2181.