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

Please fax to:
Medi-Pak Advantage
Fax: 877-482-9749

OUT OF NETWORK PROVIDER EXCEPTION REQUEST FORM

(Please note- This form does not constitute that an exception has been allowed, unless you receive written confirmation from Medi-Pak Advantage. Failure to obtain an approval may result in a reduction of payment based on the benefit plan.)

Date Request Submitted: _____

Name & Phone # of person completing this form: _____

Date of Appointment: _____

Patient Name: _____

Member ID #:_____**Date of Birth:** _____

This Exception Request is for:

_____

Hospital/Physician name: _____

Address:

_____

Please have physician complete this area:

Diagnosis:

_____

Treatment Plan:

_____

_____

Medical necessity for seeking treatment out of network:

_____

_____

_____