Medical Record Routing Form

Complete this form online and print. Please allow 30 days for medical record reviews.

Provider information

Patient Name

Subscriber Last Name

Contract Number (From ID Card -Include three digit prefix)

Claim Number

Date(s) of Service

Brief reason for record review request

Please print and complete. Attach the documentation and fax or mail the information to the fax number or address indicated on the medical record routing form. 100 pages or less can be faxed.

**Please note when submitting medical records: Submit the documentation needed to support the service provided to the member. Complete medical records are not routinely required and should only be submitted when requested.

Do not attach a copy of the claim form. Please send this form with the medical records to:

Mailing Address
Arkansas Blue Cross and Blue Shield
P. O. Box 2181
Little Rock, AR 72203-2181

Or fax 100 pages or less
Arkansas Blue Cross Medical Records
1-501-301-1927

Arkansas Blue MEDICARE
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