



Dependents of active employees that travel, live, or work outside the Service Area (State of Arkansas) for more than 90 days may be eligible for a temporary Out of Area Classification. If approved, the Member uses his/her Health Advantage ID Card to access services covered by Health Advantage. Services are covered at the In-Network benefit level when provided by **BlueCard** providers (Blue Cross and/or Blue Shield Traditional Network providers) and billed with the XCH prefix and the Member's ID number through the Local health plan. Claims are routed electronically to Health Advantage. If approved for payment, the Member's out-of-pocket expenses are limited to the Member's In-Network Deductible, Copayment and/or Coinsurance. The Member is responsible for the difference between the billed and allowed charges for services provided by non-participating BlueCard providers. Renewal is required annually.

APPLICATION FOR OUT OF AREA CLASSIFICATION

Subscriber ID # if current member (leave blank if new enrollee) _____

Subscriber Name _____ SSN _____

Home Phone _____

Address _____ Work Phone _____

Group name _____ Group number _____

Application is being made for which of the following: (Check one - One member per application)

- Dependent Student attending school outside the State of Arkansas for at least 90 consecutive days.
- Dependent Child living outside the State of Arkansas for at least 90 consecutive days.
- Dependent Spouse living outside the State of Arkansas for at least 90 consecutive days.

Member Information: (Member eligible for Out of Area Classification)

Member name _____

Member SSN _____ Date of Birth _____ Phone# _____

Mailing Address _____

(ID Card and benefit information mailed to the Member)

Period requested: Effective date _____ End/Renewal date _____

If Dependent Child (age 18 and under), parent or guardian name _____

If dependent student, name/location of school _____ # hrs _____

Subscriber Signature _____ Date _____

For Health Advantage Office Use Only: Class Code _____ New Application Renewal Application

Approved Not approved Effective date _____ Expiration date _____

Group Renewal Date _____ Application Renewal date _____

Health Advantage Signature _____ Date _____

(Signed copy of application mailed to Subscriber)

Mail: Health Advantage Membership, P.O. Box 8069, Little Rock, AR 72203-8069 FAX:501-301-6869