Health Advantage
An Independent Licensee of the Blue Cross and Blue Shield Association

DEPENDENT
Application for Out of Area Classification
(for services covered through BlueCard Program)

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