



P.O. Box 3688
Little Rock, Arkansas 72203-3688

OUT-OF-NETWORK REFERRAL REQUEST FAX SHEET

Please Note (Important Benefit Information):

Completing This Form Does Not Constitute an Approved Out-of-Network Referral, Unless You Receive Written Confirmation from Health Advantage via Facsimile Under Separate Cover. Failure to obtain an approval will result in a reduction or denial of services based upon the benefit plan.

Date Submitted _____

Member Name _____

Health Advantage ID # _____

Primary Care Physician _____

Phone _____ Fax _____

Diagnosis _____

Out-of-Network Physician _____

Address _____

Phone _____

For HA Use Only
Rg _____
Plan _____
HAC _____
AUTH _____
Approve _____
Deny _____

Reason for Referral _____

Services Requested _____

Confidentiality Note

This message is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, or exempt from disclosure under applicable law. If the reader of this message is not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that you are strictly prohibited from reading, disseminating, distributing, or copying this communication if you have received this communication in error.