Fax (501) 378-6647

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

OPEN ACCESS
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 #______________________________

Person Making the Request __________________________

Phone _____________________ Fax ________________

Diagnosis ____

Requested 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.