Timely Filing Review

Must attach proof of timely filing

This form should not be used for submitting medical information, any medical information submitted with this form will be returned.

Complete and return this form to the address of the applicable health plan check below (Check one):

☐ Arkansas Blue Cross and Blue Shield
P.O. Box 2181 | Little Rock, AR 72203

☐ BlueAdvantage Administrators of Arkansas
P.O. Box 1460 | Little Rock, AR 72203

☐ Health Advantage
P.O. Box 8069 | Little Rock, AR 72203

☐ BlueCard
P.O. Box 2181, Little Rock, AR 72203

☐ FEP
P.O. Box 2181, Little Rock, AR 72203

Provider information

Physician/Supplier name		Provider NPI number	
Street or PO box	**City**	**State**	**ZIP**
Provider contact name		**Phone**	

Patient information

Policyholder's name	Patient name	Patient's ID number (include alpha prefix)	
Street or PO box	**City**	**State**	**ZIP**

Original claim information

Date of service on original claim	Original claim number	SCCF number	Total charges on original claim

Additional comments

Signature	Date signed