

**Certification Request Form  
HealthChoice  
P.O. Box 700005  
OKC, OK 73107**

**APS HealthCare**

**Fax: 1-405-416-1755**

**Phone: 1-800-848-8121**

**Forms must be legible in order to be processed successfully. Please allow 48 hours for processing.**

**Requested Date of Service or Admission:** \_\_\_\_\_

**Facility address:** \_\_\_\_\_

**Physician:** \_\_\_\_\_

**Physician address:** \_\_\_\_\_

**HealthChoice Network Provider**       **HealthChoice Non-Network Provider**

**Service Type:**    Diagnostic Imaging    LTAC    Inpatient    OP Surgery  
                          Inpatient Rehab    Other: \_\_\_\_\_

**Contact Person:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Fax:** \_\_\_\_\_

**Member Name:** \_\_\_\_\_

**Member ID#:** \_\_\_\_\_

**Patient:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**Diagnosis Code(s):** \_\_\_\_\_

**CPT/HCPCS code(s):** \_\_\_\_\_

**Medical History (please attach pages as necessary):**

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**Note: Physician's letter of medical necessity or office notes may be required to document the requested information above.**

**Benefits are subject to eligibility and all HealthChoice policy provisions at the time services are incurred.**