

APS Certification Request Form
HealthChoice
55 N. Robinson Suite 600
OKC, OK 73102

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 Name: _____

Facility Address: _____

Physician: _____

Physician Address: _____

HealthChoice Network Provider

HealthChoice Non-Network Provider

Service Type: **Diagnostic Imaging** **OP Surgery**

Inpatient **LTAC** **Inpatient Rehab** **SNF**

Other: _____

Contact Person: _____ **Phone:** _____ **Fax:** _____

Member Name: _____ **Member ID#:** _____

Patient Name: _____ **Patient DOB:** _____

Diagnosis Codes: _____

CPT/HCPCS codes(s): _____

Medical History (please attach pages as necessary):

Note: Physician letter of medical necessity or office notes will be required to document the medical necessity for the requested services.

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