



APS Healthcare, Inc.  
 4545 Lincoln Ave, Suite 103  
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 800-762-1639 (fax)

## Inpatient Prior Authorization

Date: \_\_\_\_\_ Time: \_\_\_\_\_

**TYPE OF FAX:** (Mark only ONE of the following)

**Clinical:**

- TFC Admission Request
- TFC Extension Request
- RTC Extension Request
- Downgrade Request
- Reconsideration Request

**Clerical:**

- Transfer Request
- Correction Request
- Admit/Discharge Notice
- Provider Change of Demographic Info
- Pending Eligibility Response
- Status Request

### PATIENT INFORMATION

**RE: Patient Name:** \_\_\_\_\_  
First MI Last Designation (Jr, III, etc)

**RID :** \_\_\_\_\_ **PA# (if applicable)** \_\_\_\_\_

### PROVIDER INFORMATION

**Contact Name/Title:** \_\_\_\_\_

**FROM:** TX Facility/CMHC **OR** DHS/OJA County Office: \_\_\_\_\_

TX Facility/CMHC **OR** DHS/OJA County Address: \_\_\_\_\_

\_\_\_\_\_  
City State Zip Code

**Fax:** (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **Phone:** (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Area Code Area Code

Provider # (if applicable): \_\_\_\_\_

# Of Pages (including this page): \_\_\_\_\_

Comments: (NO clinical information) \_\_\_\_\_

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