

MST Request for Prior Authorization

Member Name:
Provider Number:
Date Completed:

APS Healthcare, Inc.
4545 N. Lincoln Blvd., Suite 103
Oklahoma City, OK 73105
800-762-1560 (Main)/800-762-1639 (Fax)

MST REQUEST FOR PRIOR AUTHORIZATION

04-20-09

Fax Date:

Organization

Provider ID number

Requesting Staff

Phone Number Fax #

Authorization Type

Start date for this request

PG016 – Level MST Team (model fidelity) WILL BE ISSUED FOR 6 MONTHS

Review Type

<input type="checkbox"/>	MST – Initial Request
<input type="checkbox"/>	MST – Extension Request
<input type="checkbox"/>	Correction Request
<input type="checkbox"/>	Important Notice Response
<input type="checkbox"/>	Pending Eligibility/Courtesy Review Response
<input type="checkbox"/>	Other _____

Consumer Information

SoonerCare ID #

Social Security #

Date of Birth

Last Name

First Name

Middle Initial Designation (Sr., Jr., III, etc.)

Comments:

CONFIDENTIALITY

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