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

COURTESY REVIEW RESPONSE

DATE: _____

FACILITY/AGENCY: _____

PROVIDER ID #: _____

AGENCY FAX NUMBER: _____ **AGENCY PHONE NUMBER:** _____

MEMBER NAME: _____
First, MI, Last, Designation (Sr., Jr., III, etc.)

RECIPIENT ID #: _____

CARECONNECTION RID: _____

If name or recipient ID has changed since request was originally submitted, please complete the following information. APS will need the original name and recipient ID as well as the new to complete the request.

NEW MEMBER NAME (if applicable): _____

NEW RECIPIENT ID # (if applicable): _____

COMMENTS: (NO clinical information) _____

CONFIDENTIALITY

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