

APS Healthcare, Inc.
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(Revised 01-12-11)

OUTPATIENT TRANSFER REQUEST

FROM: FACILITY/AGENCY NAME: _____

FACILITY/AGENCY FAX NUMBER: _____

FACILITY/AGENCY PHONE NUMBER: _____

OLD PROVIDER ID #: _____

OLD CASE MGMT ID #: _____

NEW PROVIDER ID #: _____

NEW CASE MGMT ID #: _____

TRANSFER EFFECTIVE DATE: _____

RE: OLD CLIENT NAME: _____

OLD RECIPIENT ID #: _____

NEW CLIENT NAME: _____

NEW RECIPIENT ID #: _____

*****If this transfer is a result of a new client SoonerCare ID, complete a new 23 CDC using the new SoonerCare ID to avoid this request going in to Hold_PA status delaying the completion of the transfer.*****

COMMENTS: (NO clinical information) _____

CONFIDENTIALITY

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