PACT 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)

PACT REQUEST FOR PRIOR AUTHORIZATION

Rev 04-03-09

Fax Date:	
Organization	
Provider ID number	
Requesting Staff	
Phone Number	Fax #
Authorization Type	PACT
Start date for this request	

PG018 – PACT – 1888 units WILL BE ISSUED FOR 12 MONTHS

Review Type

______PACT – Initial Request
______PACT – Extension Request
______Correction Request
______Important Notice Response
______Pending Eligibility/Courtesy Review Response
______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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