Illinois Medicaid
Outpatient Services Prior Authorization Form

Fax (866) 867-9953

SELECT THE APPROPRIATE REQUEST TYPE

☐	**Standard Request**	Allow five business days for review of prior authorization requests with receipt of clinical information. If a response has not been received after five business days, call (800) 504-2766 to confirm your request has been received.			
☐	**Priority Request**	Please process ASAP as these services are scheduled on the following date:	**Date**		
☐	**Expedited Request**	By signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.			
☐	**Additional Visits Request**	Please review the following additional information to support our request:	**Number Additional Days**	**Authorization Number**	

Physician Signature Validating Expedited Request ________________ **Date Signed** ________________

MEMBER INFORMATION

Last Name		**First Name**		**Date of Birth**	
Harmony ID Number		**Phone Number**		**Other Insurance**	

REQUESTING PROVIDER INFORMATION

Provider Last Name		**Provider First Name**		**Provider ID**	
Provider Type	☐ PCP ☐ Specialist	**Specialty**		**Participating**	☐ Yes ☐ No*
Phone Number		**Fax Number**		**Office Contact**	
Street Address		**City, State**		**Zip Code**	

TREATING PROVIDER INFORMATION

Provider Last Name		**Provider First Name**		**Provider ID**	
Phone Number		**Fax Number**		**Participating**	☐ Yes ☐ No*
Street Address		**City, State**		**Zip Code**	

FACILITY INFORMATION

Type	☐ Office	☐ Clinic	☐ Outpatient Hospital	☐ Free Standing Facility	
Facility Name		**Facility ID**		**Tax ID**	
Phone Number		**Fax Number**		**Hospital Contact**	
Street Address		**City, State**		**Zip Code**	

REQUESTED SERVICE(S)

NOTE: Requests for Advanced Radiology services should be sent to CareCore National.

Date(s) of Service		**Continuation of Care**	☐ Yes ☐ No
Procedure		**CPT Code(s)**	
Diagnosis		**ICD-9 Code(s)**	

Please attach documentation to support medical necessity. This includes H&P, progress notes, lab results and treatment plans.

Clinical Summary	

***NOTE**: If this request is for out-of-network services, please provide an explanation.

Authorizations will be given for medically necessary services only; it is not a guarantee of payment. Payment is subject to verification of member eligibility and to the limitations and exclusions of the member's contract. Emergency care does not require prior authorization. An emergency is a medical condition manifesting itself by acute symptoms of sufficient severity which could result (without immediate medical attention) in serious jeopardy to the health of an individual. *Urgent care is defined as medically necessary treatment for an injury, illness or type of condition (usually not life threatening) which should be treated within 24 hours.