Completion of all fields is required.

❑ **URGENT REQUEST**

Per health care reform, urgent means medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the patient's life/health, or the patient's ability to regain maximum function or in the opinion of the attending or consulting physician, would subject the patient to severe pain that could not be adequately managed without the requested care or treatment.

❑ **Health Alliance Utilization Management and Risk Adjustment Solutions Department**
Fax 217-902-9771
❑ **Health Alliance Pharmacy Department**
Fax 217-902-9798

Health Alliance℠

REQUEST FORM

MEDICAL RECORDS MUST ACCOMPANY ALL REQUESTS

To be completed for **ALL** requests. Please print clearly. Incomplete or illegible information will delay the review process.

Date

Patient Name | Patient Health Alliance ID Number | Patient Birthdate

Requesting Physician's Name and NPI | Requesting Physician's Phone Number ( ) | Requesting Physician's Fax Number ( )

Diagnosis Code: _____ Diagnosis: _____

Procedure Code: _____ Procedure: _____

❑ Inpatient Procedure (services provided may result in admission) Anticipated Length of Hospital Stay _____

Facility | Practitioner | Provider Phone Number ( ) | Provider Fax Number ( )

Physician Signature _____ Date _____

Tertiary/Out-of-Network Referrals

Referred to: _____ _____
Physician Facility

Physician Phone Number ( ) _____ Physician Fax Number ( ) _____

Service Reason:
❑ Consult ❑ Consult and Treatment
Visits: _____ Length of Referral: _____

Reason for Request:
❑ Not Available in Network ❑ Unable to Schedule in Timely Manner ❑ Member Request
❑ Other *[please specify]* _____

❑ The patient has been encouraged to contact Health Alliance to verify coverage for visiting this provider.

Physician Signature _____ Date _____

Pharmacy Medical Exception/Rx Preauthorization (Fax to 217-902-9798)

Drug Requested | Strength | Diagnosis

List [1] Therapy failure on formulary drugs in the same therapeutic/disease class, [2] Why failed, and [3] Medical rationale for request.

1) _____

2) _____

3) _____

Physician Signature _____ Date _____