

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



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 _____