Date: _________________

Automated Health Systems
1375 E. Woodfield Rd., Suite 600
Schaumburg, IL 60173
Attention: Provider Services Unit

Fax 847-995-0827

To Whom It May Concern:

This letter is to request to change my Illinois Health Connect (IHC) panel restrictions.

Provider/Site Name:	
IHC ID Number:	
HFS Number:	

Restrictions that should appear on my provider profile:

(Please complete only restrictions that need changing. If there are no changes please leave blank.)

1. **I would like to increase/decrease my panel size from ____________** to ___________
2. **Age Limit Low (*for all IHC patients*):___________Age Limit High (*for all IHC patients*):** __________
3. **Gender Specific (*for all IHC patients*): Female__________ Male_________ Both_________**
4. **Accepting Newborns: Yes___________ No___________**
   Is the provider willing to accept IHC newborns ***regardless of existing patient status****?* [1]
5. **Pregnant Women Accepted? Yes ____________ No___________**
   Is the provider willing to provide primary care to pregnant women in IHC?
6. **I would like to accept Existing Patients Only: Yes _______ No___________**
   Is the Provider willing to accept only those patients who have any paid claims history with this provider? If "No", the Provider will receive patients never seen before on Medicaid ("new") on the panel roster.
7. **Family Members Accepted? Yes ____________ No___________**
   Is the Provider willing to accept a new IHC patient that is included within the same Medicaid "case" of one of their current existing patients?

---

8. **May We Auto-Assign? Yes _____________ No __________**
   Is the provider willing to accept new patients through the auto-assignment process?
9. **May We Auto-Assign Existing Clients? Yes ____________ No __________**
   Is the provider willing to accept patients through the auto-assignment process who have any paid claims history with this provider?
10. **May We Auto-Assign Family Members? Yes ___________ No___________**
    Is the provider willing to accept patients through the auto-assignment process that are part of the same Medicaid "case" of one of their current existing patients?

Other Comments: ____

Sincerely,

____
Physician's Signature (or Authorized Signature)

____

****ATTENTION: Please Allow 2-3 Business Days for Processing**. You will receive a confirmation by phone once form has been processed. If no confirmation has been received, please follow up on this request.

NOTICE: Does the Provider want to continue to receive the Mailed Panel Roster?
Yes __________ No___________

[1] Both new and existing patients less than 91 days