Fax 847-995-0827

Purpose: *The purpose of this form is to identify and register affiliation/s or "care-sharing" arrangement between providers with Illinois Health Connect (IHC). IHC expects that providers who are affiliated with one another will share medical records and reports when they provide cross coverage for mutual patients. This is a medical relationship which involves care-sharing arrangement while maintaining continuity of care for all IHC patients.*

Who can Affiliate: *IHC PCPs may affiliate with each other. Affiliations can be established between partners in the same group but affiliation can also be created between practitioners who routinely provide cross-coverage for each other. At this time no referrals are necessary between providers who are affiliated.*

Important Definitions:

- **Affiliate:** *Registered care sharing arrangement between 2 or more providers so that no referral is necessary. For Example:*
  - *Partners within the same practice*
  - *Physicians who routinely alternate calls and/or vacations*
- **Unilateral-** *Gives permission to second provider to see your patients without a referral*
- **Reciprocal-** *Allows both or all providers to see each other's patients. Reciprocal affiliations require signed approval from both or all providers.*

Directions: *All the information listed below should be completed to register. IHC requires requesting provider, or the clinic's designated office staff, to sign the Affiliation Request application before submitting for registration. If affiliations are to be reciprocal, then signatures are required on behalf of both groups. Affiliations will not be registered until all applicable signatures are obtained. The completed form should be faxed to 847-995-0827.* ***ATTENTION: Please Allow up to 5 Business Days for Processing.** You will receive a confirmation by phone once form has been processed. ****Affiliation can be terminated upon request.***

Your name: _____

Location of Service (Address): _____

_____

Contact Phone Number: _____

Name of the group: _____

- **If part of group, then need to complete a group list page (see next page)**

_____ Date_____
Requesting Provider's Signature (or Authorized Signature)

(***Please Note:** *This section is only required if affiliations are reciprocal.)*

Affiliated provider (or group authorized person)'s name: _____

Location of Service (Address): _____

_____

Contact Phone Number: _____

Name of the group: _____

- **If part of group, then need to complete a group list page (see next page)**

_____ Date_____
Affiliated Provider's Signature (or Authorized Signature)

Group Name: _____

PROVIDER NAME	**HFS NUMBER**

Group Name: _____*If a second group is applicable*_____

PROVIDER NAME	**HFS NUMBER**

Illinois Health Connect (IHC): Provider Initiated Request to Add an Affiliation
Fax Completed Form to: 847-995-0827

REQUESTING PROVIDER/SITE NAME	HFS NUMBER	AFFILIATED PROVIDER/SITE NAME	HFS NUMBER	Unilateral or reciprocal affiliation?

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