

Illinois Health Connect: Provider Initiated Request for Client Reassignment Form
Fax Completed Form to: 847-995-1021 *Incomplete forms will be returned*

Client Name: _____ Date of Request: _____
DOB: _____ RIN# _____

Please Initial Reason for Requesting Reassignment:

(PCPs are referred to section D of the IHC PCP Handbook available at www.illinoishealthconnect.com)

- _____ Client is a family member of a patient who is being terminated for cause
Name and DOB of family member terminated for cause _____ List Cause: _____
- _____ Client disagrees with treatment plan. **(PLEASE PROVIDE ADDITIONAL INFORMATION BELOW)**
- _____ Client refuses to comply with treatment plan. **(PLEASE PROVIDE ADDITIONAL INFORMATION BELOW)**
- _____ Client requires services more readily available through another provider/health plan.
- _____ PCP disagrees with definition "existing patient" and does NOT have therapeutic relationship with client.
- _____ Client has violated the "no show" office policy. **Dates of "no show"** _____
- _____ Client has an outstanding balance. Date(s) of service that payment is owed: _____
- _____ Client was physically abusive or Client used threatening language.
- _____ Client has violated narcotic prescribing contract.
- _____ Client is too old for pediatric practice and has been notified by pediatrician to seek adult care.
- _____ Other

Please describe events leading to request for reassignment and efforts to educate client:

(Attach additional documentation such as 30-day letter, chart notes, etc if necessary)

All providers (include partners if applicable) from whom the client should be terminated: (attach list if necessary)

PCP/SITE NAME	HFS#	IHC PCP ID# (by site)
----------------------	-------------	------------------------------

1. _____

2. _____

I certify that the termination policies applied to this client are non-discriminatory and apply to all patients in this practice regardless of payer-status. For terminations based on failure to pay, I certify that no claims for these services have been submitted to IDHFS. I will continue to see this patient until IHC has provided official written notice about this reassignment request.

*****Provider Signature:** _____ **Date:** _____

*****Office Staff Responsible For Processing This Form:** _____

*****Return Fax Number** _____ *****Phone Number:** _____

IHC OFFICE USE ONLY:

Medical Director Review Date: _____ Approved _____ Denied _____
Comments:

No Reassignment Completed:

Reassignment Completed to PCP/Site:

IHC#

Effective Date:

IHC Processing Completion Date: _____ By (name of IHC Provider Relations Staff): _____