Illinois Health Connect: Provider Initiated Request for Client Reassignment

Fax Completed Form to: 847-995-1021

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.
________ Client refuses to comply with treatment plan.
________ 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.
________ Client used threatening language.
________ Other

***PCP certifies that no claims for these services have been submitted to IDHFS**_________________________________

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)

Providers from whom the client should be terminated: (attach list if necessary)

Name **HFS number** **IHC PCP ID # (by site)**

1.____

2.____

3.____

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.____________________ **(Provider initials)**

Office staff responsible for processing form____

Return Fax number____

I certify that I will continue to see this patient until IHC has provided official written notice about this reassignment request_______________________________________**(Provider initials)**

Provider Signature: _________________________________ **Date:** ______________________________________

IHC OFFICE USE ONLY

Medical Director Review: Date________________ Status_________________________
Comments:____

IHC Processing Completion Date: