*****PLEASE NOTE THIS FORM IS VALID ONLY FOR ILLINOIS HEALTH CONNECT PCCM PATIENTS. FOR ACE/CCE PATIENTS, YOU ARE REQUIRED TO CONTACT THE ACE/CCE PLAN WITH YOUR REQUESTS*****

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#**

_____

_____

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:

Provider Services Mgr. 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 Services Staff)_____