ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
ILLINOIS HEALTH CONNECT (IHC)
SPECIALIST DATABASE FORM
FAX # 847-995-0827

General Provider Demographic Information

Specialist Name:

HFS Provider Number (*Medicaid Number*):

National Provider Identifier (NPI) Number:

Person Completing Form (*if different from above*):

Mailing Address (*for IHC correspondence*):

Mailing Address (cont.):

City:

State:

Zip Code:

Provider Type:

Physician

Provider Specialty (*e.g., Pediatric Pulmonology, Adult Cardiology, etc.* ***List all***):

License Number: (*may be same as HFS Provider Number)*

Provider Gender: ☐ Male ☐ Female

Board Certified? ☐ Yes ☐ No

List **ALL** Certifications:

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Provider Affiliation Information

Specialist Name: ____________________

HFS Provider Number (*Medicaid Number*): ____________________

Hospital Privileges:

Hospital Name: ____________________

☐ Admitting ☐ Delivery ☐ Arrangement[1], List Physician Name: ____________________

Hospital Name: ____________________

☐ Admitting ☐ Delivery ☐ Arrangement, List Physician Name: ____________________

Hospital Name: ____________________

☐ Admitting ☐ Delivery ☐ Arrangement, List Physician Name: ____________________

Hospital Name: ____________________

☐ Admitting ☐ Delivery ☐ Arrangement, List Physician Name: ____________________

Partners and Cross Covering Physicians[2]:

Name of Covering Physician:	HFS Provider Number (*Medicaid Number*):	Begin Date[3]:

Name of Covering Physician:	HFS Provider Number (*Medicaid Number*):	Begin Date:

Name of Covering Physician:	HFS Provider Number (*Medicaid Number*):	Begin Date:

Name of Covering Physician:	HFS Provider Number (*Medicaid Number*):	Begin Date:

(Please attach additional pages if there are any other hospital privileges or partners and cross covering physicians).

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[1] If this Provider does not have direct admitting or delivery privileges but has an arrangement with another physician to admit for him/her, please list here.

[2] List all physicians who might cover for this Provider for outpatient visits, or see the Provider's IHC patients. These covering physicians must have a HFS Provider Number, but do not have to be enrolled in Illinois Health Connect.

[3] The date in which this physician can start covering for the Provider.

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General Location of Service Information

Specialist Name:

HFS Provider Number (*Medicaid Number*):

Location of Service Name (*Clinic or Practice Name*):

Office Contact Name (*e.g., Office Manager, Billing Clerk, Credentialing Staff*):

Address:

Office Contact Phone:

Office Contact Email:

Address cont.

Scheduling Contact Name (*usually reception*):

City:

Scheduling Contact Phone

Scheduling Contact Email:

State:

Office Phone:

Office Fax:

Zip Code:

County:

Office Email:

Medical Appointment Hours and Days:

Monday:	**Tuesday:**	**Wednesday:**	**Thursday:**	**Friday:**	**Saturday:**	**Sunday:**
AM- PM	AM- PM	AM- PM	AM- PM	AM- PM	AM- PM	AM- PM

Scheduling Information not listed above (*e.g., "open every other Saturday", "Walk-ins on Tuesday", etc.*):

After Hours Phone:

How will after hours access be handled (*check one*):

- ☐ Call Answering Service
- ☐ Call Physician Home/Cell
- ☐ Call Physician Pager
- ☐ Call Nurse/Medical Provider
- ☐ Other (*please specify in comments*)

Comments on after hours access:

General Location of Service Information (cont.)

List all languages in which the provider and/or office staff are conversant:

Does location have access to a Telecommunications Device for the Deaf Teletype (TDD/TTY)?
☐ Yes ☐ No If yes, please provide the number:

Question	Yes	No
Are Signing Services Available for the Deaf/Hearing Impaired?	☐ Yes	☐ No
Does location utilize the HFS MEDI system to verify eligibility?	☐ Yes	☐ No
Is Location Wheelchair Accessible?	☐ Yes	☐ No
Does Location Have Internet Access?	☐ Yes	☐ No
Does Location Submit Claims Electronically?	☐ Yes	☐ No
Does Location have Recipient Eligibility Verification (REV) agreement ?	☐ Yes	☐ No
Does the Practice include Special Needs Consumers?	☐ Yes	☐ No
Are the Special Needs – Behavioral?	☐ Yes	☐ No
Are the Special Needs – Physical?	☐ Yes	☐ No

Driving Directions *(e.g., cross-streets, main intersection, landmarks, etc.):*

Public Transportation Access

Location of Service Comments (*e.g. parking access, etc*.):

Please describe the availability of your specialty services so that IHC staff can determine which patients are most appropriate.

Patient Age Limit Low: Patient Age Limit High

Check ONE of the following choices:

Accepts Referrals with Restrictions? ☐ Yes ☐ No
If yes, please indicate restrictions in "COMMENTS" below.

Only accepts Internal (group, organization, clinic practice) referrals? ☐ Yes ☐ No
If yes, please indicate name of organization in "COMMENTS" below:

Accepts Referrals without Restrictions? ☐ Yes ☐ No

COMMENTS: (*Please include any description about your specialty services that will assist IHC staff in determining which patients are most appropriate.)*