Health Alliance

❑ **Health Alliance Main Office–Urbana** *Fax (217) 337-8440 (Medical Management)*	❑ **Macomb** *Fax (217) 698-8976*
❑ **Pharmacy** *Fax (217) 255-4598*	❑ **Ottawa** *Fax (217) 337-8440*
❑ **Ames** *Fax (515) 296-2545*	❑ **Southern (Urbana)** *Fax (217) 255-4671*
❑ **Quad Cities** *Fax (515) 296-2545*	❑ **Decatur (Urbana)** *Fax (217) 255-4671*
	❑ **Springfield** *Fax (217) 698-8679*

REQUEST FORM

MEDICAL RECORDS MUST ACCOMPANY ALL REQUESTS

Section 1—To be completed for **ALL** requests. Please print clearly. Incomplete or illegible information will delay review process.

Reason for Request:
❑ Not Available in Network ❑ Unable to Schedule in Timely Manner ❑ Member Request
❑ Other *[please specify]* ______

Date ______

Patient Name ______ Patient Health Alliance ID Number ______ Patient Birthdate ______

Requesting Physician's Name ______ ( ) Requesting Physician's Phone Number ______ ( ) Requesting Physician's Fax Number ______

Diagnosis: ______

Services Requiring Preauthorization

Services Requested ______ Procedure Code ______ Date Scheduled ______

Facility ______ Practitioner ______ ( ) Provider Phone Number ______ ( ) Provider Fax Number ______

Physician Signature ______ Date ______

Tertiary/Out-of-Network Referrals

Referred to: ______ Physician ______ Facility

Physician Phone Number ( ) ______ Physician Fax Number ( ) ______

Service Reason:
❑ Consult ❑ Consult and Treatment
Visits: ______ Length of Referral: ______

❑ The patient has been encouraged to contact Health Alliance to verify coverage for visiting this provider.

Explanation of Services Requested ______

Physician Signature ______ Date ______

Pharmacy Medical Exception/Rx Preauthorization (Fax to (217) 255-4598)

Drug Requested ______ Strength ______ Diagnosis ______

List [1] Therapy failure on formulary drugs in the same therapeutic/disease class, [2] Why failed, and [3] Medical rationale for requesting non-formulary drug.

1) ______

2) ______

3) ______

Physician Signature ______ Date ______

For office use only:

Date received at Health Alliance ______ Reference No. ______ ❑ Disapproved ❑ Approved ❑ Consult only ❑ Consult and treatment Number of visits ______

Comments: ______ Staff initials: ______

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