

# Completion of all fields is required.

## URGENT REQUEST

Per health care reform, urgent means medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the patient's life/health, or the patient's ability to regain maximum function or in the opinion of the attending or consulting physician, would subject the patient to severe pain that could not be adequately managed without the requested care or treatment.

Health Alliance Utilization Management and Risk Adjustment Solutions Department  
Fax 217-902-9771  
 Health Alliance Pharmacy Department  
Fax 217-902-9798



## REQUEST FORM

**MEDICAL RECORDS MUST ACCOMPANY ALL REQUESTS**

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

Date \_\_\_\_\_

Patient Name \_\_\_\_\_

Patient Health Alliance ID Number \_\_\_\_\_

Patient Birthdate \_\_\_\_\_

Requesting Physician's Name and NPI \_\_\_\_\_

( )  
Requesting Physician's Phone Number \_\_\_\_\_

( )  
Requesting Physician's Fax Number \_\_\_\_\_

Diagnosis Code: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Procedure Code: \_\_\_\_\_ Procedure: \_\_\_\_\_

Inpatient Procedure (services provided may result in admission) Anticipated Length of Hospital Stay \_\_\_\_\_

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: \_\_\_\_\_

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

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

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

### Pharmacy Medical Exception/Rx Preauthorization (Fax to 217-902-9798)

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 request.

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_