State of Illinois
Illinois Department of Healthcare and Family Services

Prior Approval Request Form

1. Recipient # ____
2. Recipient Name ____
3. Birthdate ____
4. Provider /NPI # ____
5. Provider Telephone # ____
6. Provider Name ____
7. Physician Name ____
8. Provider Street Address ____
9. Physician Street Address ____
10. Provider City ____ State ____ Zip Code ____
11. Physician City ____ State ____ Zip Code ____
12. Diagnosis Code ____
13. Additional Diagnosis ____
14. Diagnosis Description ____
15. Patient Height / Weight ____

16. Procedure Code ____ Description ____ Qty ____ Cat. Serv ____
Prov Charge ____ Approved HFS Amt ____ Begin Date ____ End Date ____ Pur/Rent ____ Mod ____

17. Procedure Code ____ Description ____ Qty ____ Cat. Serv ____
Prov Charge ____ Approved HFS Amt ____ Begin Date ____ End Date ____ Pur/Rent ____ Mod ____

18. Procedure Code ____ Description ____ Qty ____ Cat. Serv ____
Prov Charge ____ Approved HFS Amt ____ Begin Date ____ End Date ____ Pur/Rent ____ Mod ____

19. Procedure Code ____ Description ____ Qty ____ Cat. Serv ____
Prov Charge ____ Approved HFS Amt ____ Begin Date ____ End Date ____ Pur/Rent ____ Mod ____

20. Procedure Code ____ Description ____ Qty ____ Cat. Serv ____
Prov Charge ____ Approved HFS Amt ____ Begin Date ____ End Date ____ Pur/Rent ____ Mod ____

21. Additional Medical Necessity: ____

This is to certify that the information above is true, accurate, and complete.

22. Approving Authority Signature ____

23. Provider Signature ____ Date: ____