State of Illinois
Department of Healthcare and Family Services

PRIMARY CARE PROVIDER AUTHORIZATION
(Non-Emergency Services Only)

Section A: To be completed by the primary care provider. This form is to be used by the primary care provider for referral to another provider for the provision of necessary services or goods which the primary care provider cannot provide. It is not to be given to the patient. Prior arrangements are to be made for referred services. The form is to be sent upon completion of the arrangement for the provision of service. *The original form is to be forwarded to the referred provider with a copy maintained in the primary provider's record.*

Patient Name: _____ Recipient Number: _____

Referred Provider Name: _____

Referred Provider Address: _____

Reason for Referral: _____

_____

Date of Appointment: _____ Authorization: _____
month / day / year Primary Care Provider Signature

Address: _____

_____

Date of Referral: _____ Telephone: _____
month / day / year

REFERRED PROVIDER RESULTS

Section B: To be completed by the referred provider

Diagnosis: _____

Treatment: _____

Additional Treatment Necessary: ☐ **Yes** ☐ **No**

If yes, specify: _____

_____

Signature: _____ Date: _____

A copy of this form is to be maintained in the patient's record. The original is to be forwarded with this invoice for services rendered to:

Illinois Department of
Healthcare and Family Services
P.O. Box 19118
Springfield, IL 62794-9118

If additional services are indicated, you will receive another authorization to provide these services.

Print Form