



This prior approval is limited to outpatient examinations and laboratory studies needed to confirm a diagnosis suspected on the basis of an abnormal newborn screening test. It is to be used solely for those infants referred by the Newborn Metabolic Screening Component of the Illinois Department of Public Health's Genetic and Metabolic Diseases Program to its designated Consultants.

**To be completed by Parent/Guardian:** (instructions on reverse side of form)

1. Child's Name \_\_\_\_\_ 2. Birthdate \_\_\_\_\_ 3. Sex M  F

4. Parent/Guardian Name \_\_\_\_\_ 5. SS# \_\_\_\_\_  
(Parent/Guardian)

6. Address \_\_\_\_\_  
(Street) (City) (County) (State/Zip)

7. Daytime Telephone (\_\_\_\_\_) \_\_\_\_\_ Work  Home

8. **My Child:** Lives in Illinois? Yes  No   
Has private insurance benefits? Yes  No   
Has All Kids/Medicaid benefits? Yes  No

**Parent/Residency/Citizenship:** Lives in Illinois? Yes  No   
Is a citizen of US? Yes  No

I request assistance from the Illinois Division of Specialized Care for Children (DSCC) for my child's special diagnostic evaluation.  
I understand there will be no direct cost to me for this evaluation.  
If I have medical insurance or All Kids/Medicaid benefits which cover my child, those benefits must be used before DSCC can help.  
I understand that if additional assistance is needed from DSCC following this evaluation, I must make separate application to DSCC.  
I authorize the hospital/clinic/physician performing this diagnostic evaluation to release to DSCC and my referring physician medical reports of the evaluation and other information required for payment of their claim.

\_\_\_\_\_  
Signature of Parent/Guardian \_\_\_\_\_ Date

**To be completed by Diagnostic Center:** (instructions on reverse side of form)

9. Referring Physician \_\_\_\_\_ 10. Referral Date \_\_\_\_\_

11. Suspected Condition:  Amino Acid Disorder (including Phenylketonuria)  Biotinidase Deficiency  Cystic Fibrosis  
 Fatty Acid Oxidation Disorder  Galactosemia  Organic Acid Disorder  Pompe's Disease

12. Evaluating Hospital/Clinic \_\_\_\_\_

13. Designated Consultant \_\_\_\_\_ 14. Appointment Date \_\_\_\_\_

**DIAGNOSTIC EVALUATION REPORT** (add pages if necessary)

15. Relevant Findings:  
16. Diagnosis Confirmed (if any):  
17. Recommendations:  
18. Date of Evaluation(s) \_\_\_\_\_ 19. \_\_\_\_\_  
Signature of Designated Consultant

<p>20. <b>Send this form to:</b> DSCC Regional Office servicing the child's home community. If unknown, send to office closest to child's home community. (See reverse side for listing.)</p>	<p>21. <b>Send billing to:</b> Division of Specialized Care for Children Claims Services 3135 Old Jacksonville Road Springfield, IL 62704-6488 1-877-791-5170</p>
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**Instructions (Please print or type all information requested.)**

1. Child's legal name: first name, last name.
2. Child's birthdate: month/day/year.
3. Child's sex: male or female.
4. Parent or guardian's name: first name, last name.
5. Parent or guardian's SS#: Social Security number.
6. Parent or guardian's mailing address: street, city, county, state, and zip code.
7. Telephone number where parent/guardian can be reached during the day.
8. My Child: Lives in Illinois; has private insurance benefits; has All Kids/Medicaid benefits.  
Parent/Residency/Citizenship: Lives in Illinois, is a citizen of U.S.
9. Name of the physician who referred the child for the diagnostic evaluation.
10. Date child referred by physician on line 9 for diagnostic evaluation: month/day/year.
11. Check the suspected condition.
12. Name of hospital or clinic that is evaluating child.
13. Name of IDPH designated care coordinator.
14. Date of appointment made for the diagnostic evaluation: month/day/year.
15. Clinical/laboratory findings relevant to condition checked in line 11.
16. Diagnosis confirmed by diagnostic evaluation. If no diagnosis confirmed, write NONE.
17. Treatment recommendations or follow-up action necessary.
18. All dates of outpatient service required to complete diagnostic evaluation. Inpatient evaluations MUST have DSCC Director's prior approval and should not be reported on this form.
19. Signature of designated consultant to IDPH Genetic and Metabolic Diseases Program.
20. Send this diagnostic evaluation report to the DSCC Regional Office serving the area of parents' residence.  
See list of Regional Offices below. Report MUST be received within 30 (thirty) days of service.
21. Send bills to Springfield address provided. Bills will NOT be paid if received more than 9 (nine) months from date of service.

**DSCC REGIONAL OFFICES**

**CHAMPAIGN** Regional Office

510 Devonshire, Suite A  
Champaign, IL 61820-7306  
(217) 333-6528 (Voice)  
(217) 244-8390 (TTY)

**CHICAGO NORTH** Regional Office (M/C 419)

722 West Maxwell, Suite 350  
Chicago, IL 60607-5017  
(312) 433-4114 (Voice)  
(312) 433-4122 (TTY)

**DUPAGE** Regional Office

8205 South Cass Ave., Suite 110  
Darien, IL 60561-5319  
(630) 964-9887 (Voice)  
(630) 964-9603 (TTY)

**MARION** Regional Office

State Regional Office Building  
2309 West Main Street, Ste. 119  
Marion, IL 62959-1195  
(618) 997-4396 (Voice)  
(618) 993-2481 (TTY)

**NORTH COOK COUNTY** Regional Office

8609 W. Bryn Mawr, Suite 202  
Chicago, IL 60631-3524  
(773) 444-0043 (Voice)  
(773) 444-0178 (TTY)

**OLNEY** Regional Office

1102A South West Street  
P.O. Box 159  
Olney, IL 62450-0159  
(618) 395-8461 (Voice)  
(618) 392-3869 (TTY)

**PEORIA** Regional Office

7013 North Stalworth Drive  
Peoria, IL 61615-9465  
(309) 693-5350 (Voice)  
(309) 693-5345 (TTY)

**ROCKFORD** Regional Office

State Regional Office Building  
4302 North Main Street, Room 106  
Rockford, IL 61103-1209  
(815) 987-7571 (Voice)  
(815) 987-7995 (TTY)

**ROCK ISLAND** Regional Office

Rock Valley Office Park  
4711 - 44<sup>th</sup> Street, Suite #1  
Rock Island, IL 61201-7169  
(309) 788-4300 (Voice)  
(309) 788-6443 (TTY)

**ST. CLAIR** Regional Office

1734 Corporate Crossing, Suite1  
O'Fallon, IL 62269-3734  
(618) 624-0508 (Voice)  
(618) 624-0544 (TTY)

**SOUTH COOK COUNTY** Regional Office

6160 South East Avenue, Suite 400  
Hodgkins, IL 60525-4125  
(708) 482-0633 (Voice)  
(708) 482-1103 (TTY)

**SPRINGFIELD** Regional Office

3135 Old Jacksonville Road  
Springfield, IL 62704-6488  
(217) 524-2000 (Voice)  
(217) 524-2011 (TTY)

**Civil Rights Act Statement**

Services, financial assistance, and other benefits of the Division of Specialized Care for Children are provided on a non-discriminatory basis. No person participating in or wishing to participate in the Division's programs shall be denied benefits of the program or shall be discriminated against on the basis of sex, religion, race, color, national origin, or handicap not related to program eligibility. Individuals who believe that discrimination is being practiced by the Division of Specialized Care for Children may file a written complaint with the State of Illinois, Department of Human Rights, or the United States, Department of Education, Office of Civil Rights, or both.

State of Illinois  
Department of Human Rights  
100 West Randolph Street  
Illinois Center, Suite 10-100  
Chicago, IL 60601

United States Department of Education  
Office for Civil Rights - Region V  
401 South State Street, 7<sup>th</sup> Floor  
Chicago, IL 60605  
(312) 886-3456