SPECIALIZED CARE FOR CHILDREN

GENETIC DISEASES PROGRAM DIAGNOSTIC EVALUATION

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 ☐

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*

20. **Send this form to:**

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.)

21. **Send billing to:**

Division of Specialized Care for Children
Claims Services
3135 Old Jacksonville Road
Springfield, IL 62704-6488 1-877-791-5170

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

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

CHICAGO Home Care Office
1309 South Halsted Street, Suite 307
Chicago, IL 60607-5021
(312) 433-4100 (Voice)
(312) 433-4108 (TTY)

LOMBARD Office
1919 South Highland Ave., Suite 320A
Lombard, IL 60148-6181
(630) 652-8900 (Voice)
(630) 424-0553 (TTY)

MARION Office
2309 West Main Street, Suite 119
Marion, IL 62959-1195
(618) 997-4396 (Voice)
(618) 993-2481 (TTY)

MOKENA Office
19065 Hickory Creek Drive, Suite 340
Mokena, IL 60448-8507
(708) 326-4400 (Voice)
(708) 478-3864 (TTY)

OLNEY Office
1102 South West Street
Olney, IL 62450-1321
(618) 395-8461 (Voice)
(618) 392-3869 (TTY)

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

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

ROCK ISLAND Office
4711 - 44th Street, Suite 1
Rock Island, IL 61201-7169
(309) 788-4300 (Voice)
(309) 788-6443 (TTY)

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

SPRINGFIELD 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, 7th Floor
Chicago, IL 60605
(312) 886-3456