DIVISION OF SPECIALIZED CARE FOR CHILDREN

NEWBORN GENETIC AND METABOLIC 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 ☐
(First) *(Last)*

4. Parent/Guardian Name _____ _____ 5. Mother ☐ Father ☐ Other _____
(First) *(Last)*

6. Address _____
(Street) *(City)* *(County)* *(State/Zip)*

7. Daytime Telephone (____) _____ Work ☐ Home ☐ Cellular ☐ 8. Primary Language _____

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

I request assistance from the University of Illinois Chicago, 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 submit a 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)

10. Referring Physician _____ 11. Referral Date _____

12. Suspected Condition: ☐ Amino Acid Disorders (includes PKU) ☐ Biotinidase Deficiency ☐ Cystic Fibrosis
☐ Fatty Acid Oxidation Disorder ☐ Galactose Metabolism Disorder ☐ Hemoglobinopathies (includes sickle cell)
☐ Lysosomal Disorders (includes MPS I, MPS II) ☐ Organic Acid Disorder ☐ Spinal Muscular Atrophy

13. Evaluating Hospital/Clinic _____

14. Designated Consultant _____ 15. Appointment Date _____

DIAGNOSTIC EVALUATION REPORT (add pages if necessary)

16. Relevant Findings:

17. Diagnosis Confirmed (if any):

18. Recommendations:

19. Date of Evaluation(s) _____ 20. _____
Signature of Designated IDPH Consultant

21. **Send this form to:**	22. **Send billing to:** (800) 322-3722
DSCC Regional Office servicing the child's home community. If unknown, send to office closest to the child's home community (See reverse side for listing)	Division of Specialized Care for Children Claims Services 3135 Old Jacksonville Road Springfield, IL 62704-6488 Fax (217) 588-0773

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. Check box for relationship to child.
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. Primary language.
9. My Child: Lives in Illinois; has private insurance benefits; has All Kids/Medicaid benefits.
10. Name of the physician who referred the child for the diagnostic evaluation.
11. Date child referred by physician on line 10 for diagnostic evaluation: month/day/year.
12. Check the suspected condition.
13. Name of hospital or clinic that is evaluating child.
14. Name of IDPH designated consultant.
15. Date of appointment made for the diagnostic evaluation: month/day/year.
16. Clinical/laboratory findings relevant to condition checked in line 12.
17. Diagnosis confirmed by diagnostic evaluation. If no diagnosis confirmed, write NONE.
18. Treatment recommendations or follow-up action necessary.
19. List dates of outpatient service required to complete diagnostic evaluation, such as lab work prior to evaluation. Inpatient evaluations MUST have DSCC Director's prior approval and should not be reported on this form.
20. Signature of designated consultant to IDPH Genetic and Metabolic Diseases Program.
21. Send this diagnostic evaluation report to the DSCC Regional Office serving the area of parents' residence. See list of Regional Offices below. Use mailing address for all DSCC Regional Offices. Report MUST be received **within 30 (thirty) days** of service.
22. 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

Mailing address:

(Specific Regional Office name from list)
Division of Specialized Care for Children
3135 Old Jacksonville Road
Springfield, IL 62704-6488

Fax (217) 558-0773

Regional Office Locations:

CHAMPAIGN
Fax (217) 244-4212

CHICAGO
Fax (312) 433-4121

LOMBARD
Fax (630) 424-0669

MARION
(618) 993-8929

MOKENA
Fax (708) 478-3850

OLNEY
Fax (618) 395-2902

PEORIA
Fax (309) 693-5306

ROCKFORD
Fax (815) 987-7891

ST. CLAIR
Fax (618) 624-0538

SPRINGFIELD
Fax (217) 524-2020

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