

This prior approval is limited to outpatient examinations and/or audiological evaluations needed to confirm a diagnosis suspected on the basis of an abnormal newborn hearing screening test. It is to be used solely for those infants referred by the Illinois Department of Public Health's Early Hearing Detection and Intervention Program.

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

1. Child's Name: \_\_\_\_\_, \_\_\_\_\_ 2. Birthdate: \_\_\_\_\_ 3. Sex: M  F   
(Last Name) (First Name)

4. Parent (Mother / Father) / Guardian Name: \_\_\_\_\_, \_\_\_\_\_ 5. Birthing Facility: \_\_\_\_\_  
(Last Name) (First Name)

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

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

8. Family's Primary Language: English  Spanish  Other  \_\_\_\_\_

9. **My Child:**  
 Lives in Illinois? Yes  No  Has All Kids/Medicaid benefits? Yes  No   
 Has private insurance benefits? Yes  No  Managed Care Organization: \_\_\_\_\_

I request assistance from the UIC - Division of Specialized Care for Children 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, I understand that those benefits must be used first.  
 I understand that if additional assistance is needed from the UIC - Division of Specialized Care for Children following this evaluation, I must submit a separate application.  
 I authorize the UIC - Division of Specialized Care for Children to provide a copy of the necessary data to the Illinois Department of Public Health for the Early Hearing Detection and Intervention Program follow-up/tracking purposes.

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

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

10. Audiologist \_\_\_\_\_ 11. Initial Date of Service \_\_\_\_\_

12. Audiologist's Hospital/Clinic \_\_\_\_\_

13. Child's Primary Care Provider \_\_\_\_\_ 14. Referring Provider \_\_\_\_\_

**DIAGNOSTIC EVALUATION SUMMARY** *( attach full report(s) )*

15. Hearing Status: **Left Ear:**  Inconclusive  Normal  Confirmed Loss Type: (  Conductive  Sensorineural  Mixed  Other )  
(  Mild  Moderate  Severe  Profound )

Hearing Status: **Right Ear:**  Inconclusive  Normal  Confirmed Loss Type: (  Conductive  Sensorineural  Mixed  Other )  
(  Mild  Moderate  Severe  Profound )

16. If Inconclusive, Date(s) of Next Evaluation(s): \_\_\_\_\_  
 Has this child been referred to a Medical Provider / ENT? Yes  No

17. Additional Comments: \_\_\_\_\_

18. No. of Evaluations Attached: \_\_\_\_\_ *(Send all evaluation reports; see #20 below.)* 19. \_\_\_\_\_  
Audiologist's Signature

20. **Send this form NO LATER than 30 days from the initial date of service to:**  
 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.)*  
**Bills may be denied if this referral is not received in time.**

21. **Send billing to:**  
 UIC-Division of Specialized Care for Children  
 Claims Services  
 3135 Old Jacksonville Road  
 Springfield, IL 62704  
 1-877-791-5170

**Instructions** (Please print or type all information requested)

1. Child's legal name: last name, first name.
2. Child's birthdate: month/day/year.
3. Child's sex: male or female.
4. Parent or guardian's name: last name, first name.
5. Name of the birthing facility where the child was born.
6. Parent or guardian's mailing address: street, city, state, zip code and county.
7. Telephone number where parent/guardian can be reached during the day.
8. Family's primary language: English, Spanish or Other.
9. My Child (*check appropriate boxes*): lives in Illinois; has private insurance benefits; has All Kids/Medicaid benefits; list Managed Care org.
10. Name of audiologist who performed the diagnostic evaluation.
11. Date of the initial diagnostic evaluation: month/day/year.
12. Name of the audiologist's practice (i.e., hospital or clinic name).
13. Name of the child's primary care provider.
14. Name of the provider (*person or agency*) who referred the child for the diagnostic evaluation.
15. Please select the appropriate hearing status of the child and (if known) the type and degree of confirmed hearing loss.
16. If the result is inconclusive, please enter the scheduled date of the next diagnostic evaluation, and whether or not the child is being referred to a Medical Provider/ ENT.
17. Please enter any comments on treatment recommendations or follow-up actions necessary.
18. Please enter the number of evaluations that are attached to this form.
19. Audiologist's signature.
20. Send this diagnostic evaluation report to the Regional Office serving the area of parents' residence.  
See list of Regional Offices' addresses and contacts below. Report MUST be received within 30 days of initial date of service.
21. Send bills to Springfield address provided. Bills will NOT be paid if received more than 9 months from date of service.

**Regional Offices**

**CHAMPAIGN Core and Home Care Offices**

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

**CHICAGO Core Office**

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

**CHICAGO Home Care Offices (Regions 1 & 5)**

1309 South Halsted Street, Suite 307  
Chicago, IL 60607-5021  
(312) 433-4100 (Voice)

**LOMBARD Core and Home Care Offices (2 & 4)**

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

**MARION Office**

2309 West Main Street, Suite 119  
Marion, IL 62959-1196  
(618) 997-4396 (Voice)

**MOKENA Office**

18861 90<sup>th</sup> Avenue, Suite D  
Mokena, IL 60448-8036  
(708) 326-4400 (Voice)

**OLNEY Office**

1102 South West Street  
Olney, IL 62450-1321  
(618) 395-8461 (Voice)

**PEORIA Core and Home Care Offices**

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

**ROCKFORD Core and Home Care Offices**

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

**ST. CLAIR Core and Home Care Offices**

1734 Corporate Crossing, Suite 1  
O'Fallon, IL 62269-3734  
(618) 624-0508 (Voice)

**SPRINGFIELD Core and Home Care Offices**

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

**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

**Reporting to the Illinois Department of Public Health**

The Illinois Early Hearing Detection and Intervention Act, 410 ILCS 213, requires health care providers to report the results of diagnostic evaluations and other services for children under six years of age with suspected or confirmed hearing loss to **the Illinois Department of Public Health** within seven days of the date of service. **Fax #: 217-557-5324.**

**Early Intervention Statement**

Children under 36 months of age with a confirmed hearing loss must be referred to Early Intervention for appropriate evaluations/assessments. Please visit the Illinois Department of Human Services Locator at [www.dhs.state.il.us](http://www.dhs.state.il.us) to find the appropriate Early Intervention Child and Family Connections office by county/zip code that would serve the residence of the child/family or contact the **Bureau of Early Intervention, (217) 782-1981**, for assistance.