

GENERAL APPENDIX 10

PROVIDER FORMS REQUEST INSTRUCTIONS

The Department of Healthcare and Family Services (HFS) provides required billing forms (with the exception of the UB-04 claim form), prior approval requests forms, adjustment forms and various type of pre-addressed mailing envelopes to be used by the providers to submit claims and adjustments to the Department. Single sheet billing forms are intended for use only in laser printers. Multi-page continuous feed forms are intended for use in either typewriters or impact printers.

These materials may only be obtained by submitting Form HFS 1517, Provider Forms Request, to the Department as described below. The Department will not mail forms (except HFS 1517) in response to telephone requests. Department of Human Services offices do not maintain a supply. The provider should submit the Provider Forms Request at least three weeks in advance.

PREPARATION AND MAILING INSTRUCTIONS FORM HFS 1517, PROVIDER FORMS REQUEST

Facsimile of Form HFS 1517 is included in this Appendix. Instructions for the completion follow in the order in which the entry fields appear on the form. The form should be either typewritten or legibly hand printed.

Provider Medicaid Number, Provider Name and Address – Enter the provider name, provider number and provider type exactly as they appear on the Provider Information Sheet. Enter the name and address to which forms and envelopes are to be sent. Inclusion of the zip code is essential. Forms and mailing envelopes will be sent only to enrolled providers. HFS will not provide forms or envelopes to a billing service, unless the order includes the name and provider number of a currently enrolled medical provider on whose behalf the billing service is requesting forms.

HFS Form Number and Quantity – Enter the HFS form number(s) being requested. Generally, the form number is shown in the lower left corner of the form. In most cases, the form number format will be “HFS” followed by a number or number/alphabetical combination.

Enter the quantity of each form requested. The quantity should be in lots of 100, i.e., 100, 200, 500, etc. Please request a sufficient quantity to last three (3) months. If applicable, indicate whether the forms are to be either Continuous Feed or Snap Out.

HFS Envelope Number and Quantity – Enter the HFS envelope number being requested. The number of the envelope is shown in the lower left corner on the face of the envelope. Enter the quantity of the envelope requested. Please request a sufficient quantity to last three (3) months.

Refer to Chapter 200 of the applicable provider handbook for the form and envelope numbers appropriate for each provider type.

SUBMITTAL INSTRUCTIONS

Submit the original Provider Forms Request as follows:

Send Form HFS 1517 to:

Illinois Department of Healthcare and Family Services
Medical Desk, HFS Warehouse
2946 Old Rochester Road
Springfield, Illinois 62703-5659
Fax Number: (217) 557-6800

Order Online at <http://www.hfs.illinois.gov/forms/>



Reduced Facsimile of Form HFS 1517

Illinois Department of Healthcare and Family Services
 2946 Old Rochester Road
 Springfield, Illinois 62703-5659
 Fax Number: (217) 557-6800

Please note that claims may be submitted through the department’s Medical Electronic Data Interchange, Internet Electronic Claims (MEDI/IEC) System at: <http://www.myhfs.illinois.gov> This electronic feature allows providers to submit claims directly to the department through Internet browser software with no additional hardware or software.

PROVIDER FORMS REQUEST

TYPE OR PRINT ALL ENTRIES

ORDER REQUEST DATE: _____ **PROVIDER MEDICAID NUMBER:** _____

PROVIDER NAME: _____

STREET ADDRESS: _____ (CANNOT DELIVER TO POST OFFICE BOX)

CITY/STATE/ZIP: _____ **PHONE #:** (____) ____ - ____ **ATTENTION OF:** _____

PROVIDER E-MAIL ADDRESS: _____ (Optional)

Enter the quantity of the forms being requested in increments of 100. Please be sure to indicate the total number of individual forms or envelopes needed in the Quantity column, not the number of boxes, cases or packages.

<u>HFS Form Number:</u>	<u>QUANTITY:</u>	<u>Envelope Number:</u>	<u>QUANTITY:</u>
215CF Drug Invoice, (Continuous Feed Format)	_____	824MCR Medicare Crossover	_____
1409 Prior Approval Request	_____	1414 Special Approval	_____
1443 Provider Invoice, (Single Sheet)	_____	1415 Drug Invoice	_____
1443CF Provider Invoice, (Continuous Feed Format)	_____	1416 Adjustments	_____
2209 Transportation Invoice, (Single Sheet)	_____	1444 Provider Invoice Envelope	_____
2209CF Transportation Invoice, (Continuous Feed Format)	_____	2244 Transportation Invoice	_____
2210 Medical Equipment / Supplies Invoice, (Single Sheet)	_____	2246 Health Agency Invoice	_____
2210CF Medical Equipment / Supplies Invoice, (Cont. Feed Format)	_____	2247 Medical Equipment Supplies	_____
2211 Laboratory / Portable X-Ray Invoice, (Single Sheet)	_____	2248 NIPS Special Invoice Handling	_____
2211CF Laboratory / Portable X-Ray Invoice, (Cont. Feed Format)	_____	2294 Equip/Supplies Prior Approval	_____
2212 Health Agency Invoice, (Single Sheet)	_____	2300 Prior Approval Request	_____
2212CF Health Agency Invoice, (Continuous Feed Format)	_____	<u>Additional Forms Needed, Not Listed Above:</u>	
2360 Health Insurance Claim Form, (Single Sheet)	_____	_____	_____
2360CF Health Insurance Claim Form, (Continuous Feed Format)	_____	_____	_____
3797 Medicare Crossover Invoice (Single Sheet)	_____	_____	_____
3797CF Medicare Crossover Invoice, (Continuous Feed Format)	_____	_____	_____

Submit this form either by E-Mail, Fax, or mail to the address listed above.

GENERAL APPENDIX 11

MANAGED CARE ORGANIZATION (MCO) CONTRACTORS

COOK COUNTY

Harmony Health Plan

125 South Wacker Drive, Suite 2600
Chicago, Illinois 60606
Telephone (312) 630-2025
Fax (312) 368-1784
Member Services (800) 608-8158

Family Health Network

910 West Van Buren, 6th Floor
Chicago, Illinois 60607
Telephone (312) 491-1956
Fax (312) 491-1175
Member Services (888) 346-4968

MADISON, PERRY, RANDOLPH, ST. CLAIR AND WASHINGTON COUNTIES

Harmony Health Plan

23 Public Square, Suite 340
Belleville, Illinois 62220
Telephone (618) 236-8050
Fax (618) 233-3621
Member Services (800) 608-8158