



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 Public Health's Newborn Hearing Screening Program.

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:** Is a resident of Illinois Yes No
Has medical insurance benefits Yes No
Has KidCare/Medicaid benefits Yes No

Parent/Guardian: Is a resident of Illinois Yes No
Is a citizen of US Yes No
If no, is permanently admitted 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 KidCare/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/audiologist 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.
I authorize DSCC to provide a copy of the necessary data to the Illinois Department of Public Health for Newborn Hearing Screening Program follow-up/tracking purposes.

Signature of Parent/Guardian _____ *Date*

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

9. Referring Physician/Audiologist _____ 10. Referral Date _____

11. Evaluating Hospital/Clinic _____

12. DSCC Approved Audiologist _____ 13. Appointment Date _____

DIAGNOSTIC EVALUATION REPORT (add pages if necessary)

14. Relevant Findings (Include frequencies tested and decibels):

15. Diagnosis:

16. Recommendations:

17. Date of Evaluation(s) _____ 18. _____
Signature of DSCC Approved Audiologist

<p>19. 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.)</p>	<p>20. Send billing to: Division of Specialized Care for Children Claims Processing 2815 West Washington, Suite 300 Springfield, IL 62794-9481 1-877-791-5170</p> <div style="border: 2px solid black; padding: 5px; display: inline-block;">Start Over</div>
---	---

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: Is a resident of Illinois; has medical insurance benefits; has KidCare/Medicaid benefits. Parent/guardian: Is a resident of Illinois, is a citizen of US, if no, is permanently admitted.
9. Name of the physician/audiologist who referred the child for the diagnostic evaluation.
10. Date child referred by physician/audiologist on line 12 for diagnostic evaluation: month/day/year.
11. Name of hospital or clinic that is evaluating child.
12. Name of DSCC approved audiologist.
13. Date of appointment made for the diagnostic evaluation: month/day/year.
14. Clinical findings relevant to condition indicated on line 15.
15. Diagnosis confirmed by diagnostic evaluation. If no diagnosis confirmed, write NONE.
16. Treatment recommendations or follow-up action necessary.
17. 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.
18. Signature of DSCC approved audiologist.
19. 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.
20. 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)

HICAGO NORTH Regional Office (M/C 419)

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

CHICAGO SOUTH Regional Office (M/C 418)

1309 South Halsted Street, Suite 307
Chicago, IL 60607-5021
(312) 433-4100 (Voice)
(312) 433-4108 (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

State Regional Office Building
5415 North University Ave., Room 106
Peoria, IL 61614-4779
(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 - 44th Street, Suite #1
Rock Island, IL 61201-7169
(309) 788-4300 (Voice)
(309) 788-6443 (TTY)

ST. CLAIR Regional Office

1734 Corporate Crossing, Suite 1
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

Quantum Centre
421 South Grand West, Second Floor
Springfield, IL 62704-3769
(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