State of Illinois
Department of Healthcare and Family Services

MCH Primary Care Provider Agreement

PROVIDER INFORMATION		
Last Name, First Name, Middle Initial	Provider Number	License Number

Office Address	City	State	Zip Code

Office Phone	After Hours Phone	Fax Number

My Specialties Include: (Check all that apply)

☐ OB/GYN ☐ Pediatrics ☐ General Practice
☐ Family Practice ☐ Internist ☐ Advance Practice Nurse (APN)

I Hold Hospital Admitting Privileges at the Following Hospitals:
Note: APN's list hospitals where collaborating physician(s) have admitting privileges.

Hospital Name	Hospital Address	Delivery Priviliges Yes	No	HFS Use Only

My Other Practice Locations Include:
Note: APN's list practice locations for collaborating physician(s).

Physician or Clinic Name	Street Address/City/State/Zip	Phone

Certification

I certify that I meet the participation requirements of an MCH Primary Care Provider, as cited in Section B of the reverse page. I also understand that I must notify the Department in writing should any changes to the information contained herein become necessary. I also understand that the information I enter on this form will be used to update the Department's data base.

Requested Agreement Effective Date: ____________________

Provider Signature ______________________________ **Date** ______________

Please mail your original signed copy to: **Healthcare & Family Services**
Provider Participation Unit
P. O. Box 19114
Springfield, Illinois 62794-9114

For more information, call: (217) 782-0538

Illinois Department of Healthcare and Family Services

MCH Primary Care Provider Agreement

This Agreement pertains only to the relationship of the Illinois Department of Healthcare and Family Services with the Provider under the Department's MCH (**Maternal and Child Health**) Program. This Agreement does not affect any other relationship or agreement, including but not limited to, the general Provider Agreement, between the Department and the Provider.

Section A: Department Responsibilities

In partnership with the Provider named herein, the Department agrees to:

- pay enhanced rates for delivery services;
- pay enhanced rates for preventive and primary care office visits provided to children;
- provide expedited processing of claims with enhanced rates for Providers who meet established criteria;'
- upon request, furnish client eligibility and profiles of prior services reimbursed by the Department;
- provide support services as needed for the purpose of client follow-through on treatment regimen;
- facilitate access to medical care for clients in cooperation with the case manager through the local health department , community-based organization or certified clinic under one of the State's programs.

Section B: Participation Requirements

As a Provider in the MCH Program, I agree to:

- maintain hospital admitting privileges, or for APNs maintain a collaborative agreement with a physician who has hospital admitting privileges;
- provide periodic health screenings (EPSDT) and primary pediatric care as needed;
- provide obstetrical care, delivery services, as appropriate;
- perform risk assessment for children, pregnant women or both;
- maintain 24-hour telephone coverage for consultation including ensuring that "sick" children and "at-risk" pregnant women are treated as needed, based on triage of need;
- schedule diagnostic consultation and specialty visits or contact the designated case management entity to coordinate/schedule the visit as appropriate;
- provide equal access to medical care for clients in cooperation with the Department or its designated case management entity;
- communicate with the case management entity;
- provide a medical home for children, pregnant women or both.

Special Provisions:

You may terminate your participation as a Primary Care Provider in the MCH Program upon written notice sent to the:

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Provider Participation Unit
P.O. Box 19114
Springfield, Illinois 62794-9114

The Department may terminate a Provider's participation as a Primary Care Provider in the MCH Program under this Agreement if the provider fails to maintain any of the above participation requirements. Such termination shall not be subject to the Department's rules and regulations on notice and hearing for a Provider's termination from participation in the Medical Assistance Program.