



**HFS**

Illinois Department of  
Healthcare and Family Services

## Prior Authorization Request Form Individual and Therapeutic Support Services

Please submit completed requests to: [HFS.BHPriorAuth@illinois.gov](mailto:HFS.BHPriorAuth@illinois.gov)

Section 1. Youth Information		
Youth Name:	Date of Birth:	RIN:
Primary Diagnosis:	ICD-10 Code:	
Program Enrollment (check all that apply): <input type="checkbox"/> Pathways <input type="checkbox"/> FSP <input type="checkbox"/> SFSP		
Section 2. CCSO Information		
Provider Name:	NPI:	HFS Provider Number:
Requestor Name:	Phone:	Email:
Section 3: Requested Service Detail		
		Request type: <input type="checkbox"/> Initial <input type="checkbox"/> Update to an approved request
<b>Requested Service</b> (complete this section for all initial requests)		
<input type="checkbox"/> Therapeutic Support Services (H0046) Modality of therapy requested: <input type="checkbox"/> Equine <input type="checkbox"/> Art <input type="checkbox"/> Music <input type="checkbox"/> Dance/Movement <input type="checkbox"/> Drama <input type="checkbox"/> Horticultural		
<input type="checkbox"/> Individual Support Services (T1999). Check the specific service category requested below:		
<input type="checkbox"/> Physical wellness <input type="checkbox"/> Special or therapeutic youth development programming <input type="checkbox"/> Strengths-developing activities <input type="checkbox"/> Sensory items <input type="checkbox"/> Parent education/training		
Please describe/name the specific ISS activity, service, or good being requested: _____		
<b>Rendering/Supplying Individual or Organization:</b>		
<b>Requested Date(s) of Service:</b> Start Date: _____ End Date: _____		
<b>Requested Service Amount:</b> _____ x \$ _____ = \$ _____ <small># of Units Per unit Cost Total Cost</small>		
<b>Requested Updates</b> (only complete this section for updates to an approved request)		
HFS issued prior authorization number: _____		
Please describe what you are requesting be updated and a brief explanation of why. Please attach any additional documentation in support of this request (e.g., proof of change to cost). _____		
Section 4: Required Attachments		
<input type="checkbox"/> Copy of the youth's IM+CANS. The IM+CANS must clearly list the requested service as a recommended service and be clearly linked to a goal on the youth's treatment plan.		
<input type="checkbox"/> Verification of cost of service (e.g., invoice, receipt, program flyer, contract)		
<input type="checkbox"/> <b>TSS only:</b> verification of therapist credentials (e.g., certificate copy, license number)		
Section 5: Outcome – To Be Completed By State Reviewers Only		
<input type="checkbox"/> Approved. HFS issued prior authorization number: _____		
<input type="checkbox"/> Denied. Denial reason: _____		
<input type="checkbox"/> Pending – additional information needed: _____		
Reviewer Name: _____		Review Date: _____



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## INSTRUCTIONS

### Section 1. Youth Information

1. Youth Name. Enter the first and last name of the youth seeking the service.
2. Date of Birth. Enter the date of birth of the youth seeking the service.
3. RIN. Enter the State of Illinois recipient identification number (RIN) of the youth seeking the service.
4. Primary Diagnosis. List the name of the youth's primary diagnosis necessitating the services being requested.
5. Program Enrollment. Check all applicable boxes to indicate the youth's program enrollment.

### Section 2. CCSO Information

6. Provider Name. Enter the name of the CCSO organization making the request.
7. NPI. Enter the 10-digit NPI number associated with the CCSO making the request. This must be the NPI associated with the CCSO's IMPACT provider enrollment that will be used to submit claims for ISS and TSS.
8. HFS Provider Number. Enter the 12-digit HFS provider ID for the CCSO making the request. This must be the provider ID associated with the CCSO's IMPACT provider enrollment that will be used to submit claims for ISS and TSS.
9. Requestor Name. Enter the name of the person submitting the request. This is who HFS or its designee will contact with any questions about the request.
10. Phone. Enter a contact phone number for the person submitting the request.
11. Email. Enter a contact email for the person submitting the request.

### Section 3. Requested Service Detail

12. Request type. Check the appropriate box to indicate if this is an initial request or an update to an already approved ISS/TSS request.
13. Requested service. This section is only required for initial requests. Check the appropriate box to indicate if the request is for TSS or ISS. If TSS is selected, check the appropriate box to indicate the modality of therapy being requested. If ISS is selected, check the appropriate box to indicate the service category being requested, and then provide additional description of the specific activity, service, or good being requested in the text box below.
  - Rendering/supplying individual or organization. Enter the name of the individual or organization that will be delivering the requested service or from which the requested item will be purchased. This should match the documentation provided to verify the service cost.
  - Requested date(s) of service. Enter the start and end date on the services being requested will be rendered or purchased. If only a single date is being requested, please enter the same date in both the start and end date boxes. Please note:
    - The requested dates must fall within the youth's Pathways eligibility period.
    - If the requested dates span a new fiscal year (over July 1 to June 30), the request must be split into two separate requests.
  - Requested service amount. The number of units and per unit cost noted here must match how the provider submits claims for reimbursement.
    - # of units. Enter the number of units requested.
    - Per unit cost. Enter the cost for each unit.
    - Total cost. Enter the total cost for this request (number of units multiplied by the per unit cost).

**IMPORTANT NOTE:** Currently, the HFS claims system can only accept one claim per each approved ISS/TSS prior authorization request. Providers requesting multiple units of the same service across a date span must either: 1) wait until all units of service have been provided to the youth and bill all units on a single claim; or, 2) break up the request into multiple prior authorization requests to allow for more frequent billing.

14. Requested updates. Only complete this section if requesting an update to an approved request for any reason. Providers must also submit an update to request the prior authorization if the youth does not utilize the approved services in full for any reason (e.g. 10 sessions were approved but the youth only attended 8).
  - HFS issued prior authorization number. Enter the HFS prior authorization number issued for the approved ISS/TSS services for which a change is being requested.
  - Provide a brief description of what you are requesting be changed and why. Appropriate documentation must be submitted, as applicable, to support the change request.

### Section 4. Required Attachments.

15. A copy of the youth's current IM+CANS and verification of the cost of service being requested must be submitted with all ISS/TSS prior authorization requests. The IM+CANS must clearly document the requested service as a recommended service and be clearly linked to a goal on the treatment plan. For TSS service requests, verification of the credentials of the individual qualified in the specific TSS intervention being delivered must be submitted.