State of Illinois
Department of Healthcare and Family Services

PRIMARY CARE PHYSICIAN/PHARMACY AUTHORIZATION
(Non-Emergency Services Only)

Section A: To be completed by the primary care physician or pharmacy for referral to another provider for the provision of necessary services or goods which the primary care physician or pharmacy cannot provide. It is not to be given to the patient. Prior arrangements are to be made for referred services.
The original form is to be forwarded to the referred provider with a copy maintained in the prescribing physician's or pharmacy's record.

Patient Name: ______________________ Recipient Number: ______________________

Referred Provider Name: ______________________

Referred Provider Address: ______________________

Reason for Referral: ______________________

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Date of Appointment: ______________________
month / day / year

Authorization: ______________________
Primary Care Physician or Pharmacy Signature

Date Medication Prescribed: ______________________

Address: ______________________

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Date of Referral: ______________________
month / day / year

Telephone: ______________________

REFERRED PROVIDER RESULTS

Section B: To be completed by the referred provider

Diagnosis: ______________________

Treatment/Medication/Goods Dispensed: ______________________

Additional Treatment Necessary: Yes ☐ ☐ No

If yes, specify: ______________________

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Signature: ______________________ Date: ______________________

A copy of this form is to be maintained in the patient's record. The original is to be forwarded with this invoice for services rendered to:

Illinois Department of
Healthcare and Family Services
P.O. Box 19118
Springfield, IL 62794-9118

If additional services are indicated, you will receive another authorization to provide these services.