State of Illinois
Department of Healthcare and Family Services

Override Request Form

Provider Name _____ **DATE:**

HFS Unit

☐ **DME/Audiology** ☐ **Home Health** ☐ **Optical** X **Practitioners** ☐ **SASS** ☐ **Therapy (PT, OT and ST)**

☐ **Transportation**

The attached claim for the above mentioned participant requires review for manual payment processing for the following reason(s):

☐ **C17 Override***

C89/R36 Override Medicare Part B:

☐ No Medicare Part B or no longer active

☐ Medicare Denial due to Dental or Non-covered Screening or service*

☐ Home Health - Medicare Denied - Not Homebound*

☐ Custom Wheelchair in LTC (not ICF/MR)

☐ Prior Authorization*

☐ Patient Responsibility*

D05/G55 Override Timely File:

X Backdated Eligibility

☐ 2432 Split bill Form/Spenddown Met*

☐ Adjustment/Void

☐ Due to Medicare Denial*

☐ Provider Enrollment*- New enrollment; reenrollment; category of service or new payee added

☐ TPL adjudication date*

☐ TPL recoupment date*

☐ HFS system rejection issue

Specify: _____

☐ **D78 Override**

☐ **G39 Override**

R05 Override

☐ Services not covered in facility

☐ Items supplied in LTC/DOS is date of discharge

☐ Custom wheelchair

☐ Patient owned equipment (repairs)

☐ Prior Authorization

☐ CILA Facility/Supportive Living

☐ **R16 Override**

☐ **R17 Override**

R34 Override

☐ Admission or discharge on DOS*

R35 Override Medicare Part A*

☐ Medicare Part A Exhausted

☐ No Medicare Part A

☐ Medicare Part A database discrepancies

☐ **R39 Override**

☐ **X13 Override**

☐ Deceased

☐ Discharged

☐ Began Hospice

☐ **N13 Override** ☐ **N14 Override** ☐ **N15 Override** ☐ **N16 Override** ☐ **N17 Override**

☐ **N18 Override** ☐ **N19 Override** ☐ **N20 Override**

Sender's Name Address

Contact Telephone Number E-mail Address

Comments:

*Documentation Required

HFS1624 (N-4-14)