# IDAHO DEPARTMENT OF JUVENILE CORRECTIONS

**Approval from regional Nurse Manager is required prior to appointment, except in an emergency**

## **Contract Provider Off-Site medical SERVICES request Form**

## **this section to be completed by the contract provider**

|  |  |  |  |
| --- | --- | --- | --- |
| Juvenile name: |  | Date of Birth: | IJOS# |

|  |  |  |  |
| --- | --- | --- | --- |
| Medical provider juvenile will be evaluated by: |  | Emergency – date seen: |  |
|  |  | Non-emergency | |
|  |  |  | |
|  |  |  | |

|  |  |
| --- | --- |
| Allergies: |  |

|  |  |
| --- | --- |
| Current Medications: |  |

|  |  |
| --- | --- |
| Chief Complaint: |  |
|  | |

## **This section to be COMPLETED by the idjc regional nurse manager**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date request received by regional Nurse Manager: | | | | | |  | | |
|  | | This medical request is approved. | | | | | | |
|  | | This medical request is denied or has conditions. Please contact the regional Nurse Manager for more guidance. | | | | | | |
| Date request sent back to contract provider: | | | | |  | | | |
| CONTRACT PROVIDER: FAX ALL NOTES, LABS, X-RAYS, AND REPORTS TO THE IDJC FACILITY MARKED BELOW | | | | | | | | |
|  | JCC–St. Anthony | |  | JCC–Nampa | | |  | JCC–Lewiston |
|  | Attn: Nurse Manager | |  | Attn: Nurse Manager | | |  | Attn: Nurse Manager |
|  | 2220 East 600 North | |  | 1650 11th Ave North | | |  | 140 Southport Ave |
|  | St. Anthony, ID 83445 | |  | Nampa, ID 83687 | | |  | Lewiston, ID 83501 |
|  | FAX: 208.624.3198 | |  | FAX: 208.465.8422 | | |  | FAX: 208.799.5079 |

|  |  |
| --- | --- |
| Regional Nurse Manager Signature: |  |
|  | |

## **METHOD OF PAYMENT**

|  |  |  |  |
| --- | --- | --- | --- |
| Medicaid No.: |  | Private Insurance: |  |

## IDJC Reimbursement

|  |
| --- |
|  |

## **This section to be COMPLETED by the medical provider**

|  |  |
| --- | --- |
| Date service provided: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Diagnosis: |  |

|  |  |
| --- | --- |
| Physician recommendation/orders: |  |
|  | |
|  | |
|  | |

|  |  |  |  |
| --- | --- | --- | --- |
| Physician/Provider Signature: |  | Date: |  |