# 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

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

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

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