Department of Corrections
WASHINGTON STATE

PATIENT REQUEST FOR OUTSIDE HEALTH SERVICES
SOLICITUD DE PACIENTE PARA SERVICIOS DE SALUD EXTERNO

TO BE COMPLETED BY INDIVIDUAL / *COMPLETE EL INDIVIDUO*		
Name / *Nombre*	DOC#	Facility and Unit / *Facilitad y Unidad*
Service Requested / *Servicio Solicitado*		
Service Provided By (Name and Address) / *Servicio Proporcionado Por (Nombre y Dirección)*		

DOC provides the opportunity for patients to purchase healthcare services not provided by the Washington DOC Health Plan per DOC 600.020 Patient-Paid Healthcare.

EL DOC brinda la oportunidad a los pacientes de adquirir servicios de atención médica no proporcionados por el Plan de Salud del DOC de Washington según el DOC 600.020 Patient-Paid Healthcare.

This is a written request for self-paid medical services, dental services, mental health services, or medications.

Esta es una solicitud por escrito de servicios médicos auto-pagados, servicios dentales, servicios de salud mental o medicamentos.

Signing this form authorizes the Business Office to deduct a $50 processing fee from your trust account. This fee is nonrefundable.

La firma de este formulario autoriza a la Oficina Comercial a deducir una tarifa de procesamiento de $50 de su cuenta fiduciaria. Esta tarifa no es reembolsable.

A money order from an outside source for the $50 processing fee is also acceptable and must be submitted directly to the Business Office to begin the process.

Una orden de dinero de fuente externa para los $50 tarifa de procesamiento también es aceptable y debe ser sometida directamente a la Oficina de Negocios para comenzar el procedimiento.

Payment of the fee does not guarantee the request will be approved. The fee partially covers the cost of processing the request and will not be returned even if the request is denied.

El pago de la tarifa no garantiza que la solicitud será aprobada. La tarifa cubre parcialmente el costo de procesamiento de la solicitud y no se devolverá incluso si la solicitud es denegada.

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My signature indicates that I wish to seek self-paid healthcare services not covered by the Washington DOC Health Plan and authorize the transfer of $50 from my trust account (or money order)**.**

*Mi firma indica que deseo buscar servicios de atención médica auto-pagado que no estén cubiertos por el Washington DOC Health Plan y autorizar la transferencia de $50 de mi cuenta fiduciaria (o giro postal)**.***

Signature / *Firma* _____ Date / *Fecha* _____

Printed Name / *Nombre Impreso* _____ DOC Number / *Numero de DOC* _____

Send the completed form to your facility Business Office
Envié el formulario completo a la oficina comercial de su instalación

Local Business Advisor/designee	
$50 received from: ☐ Trust account ☐ Outside source	
Signature	Date
Please forward completed form to the Health Services Manager/designee	

State law and/or federal regulations prohibit disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.