PATIENT-PAID HEALTHCARE
HOSPITAL INFORMATION

TO BE COMPLETED BY INDIVIDUAL	
Name	DOC Number
Service(s) requested	

The named individual is incarcerated at ______________________ (Facility Name) and is requesting you provide the service(s) listed above.

The Department of Corrections is **not** paying for these services. The patient will deposit funds sufficient to cover your estimated cost plus a small additional amount to cover unanticipated costs in a trust account. You will be paid from this trust account. Please provide the requested information, copy this form, and mail the original directly to:

Name: ______________________ Address: ______________________

Phone: ______________________ City: ______________ Zip: __________

TO RECEIVE PAYMENT: Complete service(s), attach a copy of this form to your final invoice, and mail to the facility's Business Office at the above address.

TO BE COMPLETED BY HOSPITAL ADMINISTRATOR	
Hospital Name	
Address	
Contact Person	Phone Number
Diagnosis	
Surgery/Procedure to be Performed	

PRESCRIPTION MEDICATIONS
If you anticipate the need for prescriptions, please attach them to this form before mailing. Non DOC formulary medications require approval. If the medication is not approved, you will be contacted. When the procedure is complete, prescriptions will be filled in a community pharmacy and administered to the patient according to established DOC protocols for medication administration. Sample medications or dispensed medications are not permitted and will be destroyed.

HEALTH SERVICE	ESTIMATED COST
Room and board	
Surgery and recovery room	
Anesthesia services	
Anesthesiologist fees	
Other ancillary services (list):	
Other professional fees (list):	
TOTAL	

WAIVER STATEMENT

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.