Medical Request for Payment Authorization
Idaho Department of Correction – Health Services

County: _____ Date: _____ Phone #: _____

Requesting Attendant: _____ Fax #: _____
(Deputy, Nurse, etc.)

Email_____

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Inmate: _____ Inmate IDOC #: _____ Date of Birth_____
Last First **(Required)**

Responsible Medical Provider: _____Date Patient Seen: _____
(Required)

Type of Service Requested
Check all that apply

- ☐ Medical Visit
- ☐ Medication Request
- ☐ Dental
- ☐ Optical
- ☐ Mental Health Visit
- ☐ Lab
- ☐ X-ray
- ☐ ER With Ambulance
- ☐ ER No Ambulance
- ☐ Move to IDOC Facility

Details of Current Illness/Injury

_____
_____
_____
_____

Treatment Plan

_____
_____
_____

List Medications Requested

Medication	Strength	Days Prescribed	Diagnosis **(Required)**

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IDOC HEALTH SERVICES RESPONSE

Approved _____ Deferred _____ Denied _____ Need More Information _____

Reason for Deferral/Denial: _____

Comments: _____

_____

_____ _____ Date of Authorization _____
Authorized Signature Title

Please send all bills/invoices to:

IDOC Health Services
Attn: Vicky Brady

1299 N. Orchard, Ste 110

Boise, ID 83721-0017

Health Services

Rona Siegert, RN 208-658-2047
Health Services Director

Zarah Martin, RN 208-672-3434

Vicky Brady, TRS II 208-658-2128

Email form to:

healthservices@idoc.idaho.gov

or Fax to: 208-327-7007