STATE OF ALASKA **DEPARTMENT OF CORRECTIONS**

PRISONER HEALTH CARE AUTHORIZATION

I. PERSONAL DATA

Institution:_____

Name:_____ D.O.B.:_____ OBSCIS #:_____
(Print or Type) Last First MI

Veteran / ANHS / Medicaid Eligible (Circle One) Private Insurance □ Yes □ No Carrier:_____

Classified:_____ Custody Level:_____ Remand Date:_____ PRD:_____ Sentenced:_____

II. SECURITY/TRANSPORTATION AUTHORIZATION (Prepared by Security)

Federal Prisoner □ Yes □ No Security Guard Scheduled:_____

Signature:_____ Title:_____ Date:_____

III. APPOINTMENT DATA

Date: _____ Time:_____ Provider:_____

Address: _____

Special Instructions: _____

(Bring X-rays, Lab, Special Prep, ETC.)

IV. MEDICAL SERVICES REQUESTED (Medical Staff Only)

□ Self-inflicted □ Sports Injury □ Work-related

Refer to:_____

Statement of Problem: (Attach appropriate documentation)

_____

_____

_____

_____ _____ _____
Medical Practitioner's Signature Title Date/Time

V. AUTHORIZATION FOR SERVICES

☐ The following services are APPROVED _____

_____

☐ The following services are DENIED _____

_____

_____ _____ _____
Authorized Signature Title Date

VI. FINDINGS, RECOMMENDATIONS AND/OR ACTION TAKEN TO INCLUDE MEDICATION Rx (Service Provider Only)

Payment may be delayed if not properly annotated: _____ (CONTINUE ON EXTRA SHEET)

_____

_____

_____

_____

_____

_____ _____ _____
Medical Practitioner's Signature Title Date/Time

SPECIAL NOTE TO PROVIDER

D.O.C. WILL NOT PERFORM OR AUTHORIZE PROCEDURES WHICH ARE ELECTIVE OR NONESSENTIAL. ALL SURGICAL RECOMMENDATIONS NOT OF AN EMERGENCY NATURE MUST BE APPROVED BY THE MEDICAL ADVISORY COMMITTEE.

BILLING INFO: When completed, the yellow copy must accompany your billing to ensure payment.
Send to: Department of Corrections, Health Care Administrator,
550 W 7th Ave Ste. 601, Anchorage Ak. 99501.

DISTRIBUTION: White: Med. Record; Yellow: Fiscal; Pink: Dept. Suspense; Green: suspense **(See Reverse)**

Form 807.02B Revision 11/08

ONLY THE 4 PART NCR PRISONER HEALTH CARE AUTHORIZATION FORM SHOULD BE USED.
THE NCR FORM MUST HAVE THE MR NUMBER IN THE LOWER RIGHT HAND CORNER TO BE VALID.

STATE OF ALASKA **DEPARTMENT OF CORRECTIONS**

PRISONER HEALTH CARE REFERRAL AUTHORIZATION FORM INSTRUCTIONS

1. Purpose: The purpose of this form is to provide a health care referral authorization, record of transportation and security, authority to bill for services, and record of action taken by provider.

2. Instructions: All blanks must have an entry.

   I. PERSONAL DATA: To be completed by the facility's medical unit and superintendent or designee.

   Name, date of birth (0.0.8,), OBSCIS #, whether Veteran / Medicaid / Alaska Native Health Service (ANHS) Eligible (circle correct response), Private Insurance carrier and institution to be filled out by medical staff - If prisoner has private insurance, write name of carrier.

   Custody level (list max., med., min., or comm.), remand date, PRD (Projected Release Date), sentenced (yes or no) to be completed by the superintendent or designee. Classified - indicate yes or no. If yes, list facility to where the inmate is classified.

   II. SECURITY/TRANSPORTATION AUTHORIZATION:

   Indicate whether or not federal prisoner. On the line titled "Security Guard Scheduled", please write whether guard is scheduled (yes or no), security guard contractor and initials of corrections official scheduling guard hire.

   Section to be completed by the superintendent or designee. Person completing this section should sign, put title, and date.

   III. APPOINTMENT DATE:

   To be completed by person making the appointment.

   IV. MEDICAL SERVICES:

   To be completed by a licensed and authorized medical practitioner or designee. Must give adequate data in the narrative. Attach appropriate documentation.

   Check if injury is self-inflicted, a sports injury, or work related.

   V. AUTHORIZATION FOR SERVICE:

   To be completed by Medical Advisory Committee (MAC), Health Care Operations Officer (HCOO) or designee.

   VI. FINDINGS. RECOMMENDATIONS, AND/OR ACTION TAKEN:

   To be completed by the provider. Should contain adequate documentation of what was found, accomplished or recommended.

3. DISTRIBUTION OF FORMS: Generally, white & yellow forms will be carried by the transportation officer to the provider: the provider will return the completed white form to the Department of Corrections and retain the yellow form, as stated below:

White (Original):	To be placed in the health care file.
Yellow (Fiscal):	To be attached to the provider's bill for service and forwarded to the Health Care Administrator, 550 W. 7th Ave, Ste 601 Anchorage, Ak. 99501
Pink (Dept. Suspense):	Health Care Administrator's suspense copy.
Green (Suspense):	Suspense copy for the facility

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