DEPARTMENT OF CORRECTIONS

Division of Adult Institutions DOC-3035 (Rev. 2/2019)

HEALTH SERVICE REQUEST AND COPAYMENT DISBURSEMENT AUTHORIZATION

WISCONSIN Adm. Code Ch. DOC 316

| é NOTIFY ANY FACILIT | Y STAFF IF YOUR HEALTH | CARE NEED | NUMBER | |
|--|--|---|--------------------|---|
| PRINT LAST NAME | PRINT FIRST NAME | | NUMBER | A32 |
| 1 Donald | - total Aldrew | | (3 O | |
| FACILITY NAME | HOUSING UNIT | TOD. | AY'S DATE | and the same and the same |
| | 93H 63 |) ! . | | Carlo |
| COPAYMENT DISBURSEMENT REQUES AGREEMENT BY PATIENT: I understand the following: The Department of Corrections shall charge I will not be denied care if I am unable to pay By signing below; I am initiating a request fo | a copayment of \$7.50 for a visit (face to face to the copayment. | nt at the time of the v | visit when a copa | yment is required. |
| PATIENT SIGNATURE | (4) (4) (4) (4) (4) (4) (4) (4) (4) (4) (4) | | | |
| | | | | |
| TO BE COMPLETED BY HSU ONLY MEDICAL (Nurse, Doctor/NP/PA) Charge Copayment: Yes No AUTHORIZED STAFF SIGNATURE | ☐ DENTAL ☐ OPTIC | DATE OF SERV | VICE | |
| TO BE COMPLETED BY INMATE PATIE | NT - HEALTH SERVICE REQUEST SE | CTION | | |
| Be sure to include today's date on top of form. completed form in the sick call box. The HSU v | Check the appropriate box below, and explai will send a copy back to you indicating that yo | n your request on the our request has beer DIES EROM HEAL | TH CARE RE | CORD (List records below) |
| PSYCHIATRIST DINFORM | MATION / OF | · (a | nore | |
| Please provide a brief description belo | ow of the services you desire so that | HSU can respon | d to your requ | est appropriately. DATE RECEIVED: |
| faceroal is | not le piùs soreuss is sacras, muscles | extre Tu se said | MEL Description | DEE STAMPED BY HS! U SEP U 3 ZUZU A NOG LAT |
| FOLD THE BOTTOM OF THE FOR | M UP TO THE DOTTED LINE SO T | HAT INFORMA | TION REMA | NS CONFIDENTIAL. |
| PATIENT: DO NOT WRITE BELOW THI | S LINE - TO BE COMPLETED BY F | ISU ONLY | | |
| 4SU RESPONSE Check appropriate box | | ation as needed. | | |
| Nursing Sick Call: Today Da | | | | |
| ☐ Scheduled to be seen in HSU: ☐ A | CP RN/LPN Special Needs Ev | | cal Other: | |
| Refer HSR to: ACP HSU M | lanager | Optical Oth | | |
| Refer for copies only | una a la martina de la mar | Refer for He | alth Care Reco | ord review appointment. |
| Educational material attached (Specif | fy): | Other: | | |
| COMMENTS / INFORMATION | | | | |
| | Trovider rep | enal o | roune | |
| | | <i>y</i> | | |
| | | | | |
| PRINT STAFF NAME | D. Henning RN | | DATE OF HSU | RESPONSE |
| SELVINI SIVILI INVINE | | | 9/2 | 12020 |
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DEPARTMENT OF CORRECTIONS Division of Adult Institutions DOC-3035 (Rev. 2/2019)

HEALTH SERVICE REQUEST

WISCONSIN

AND COPAYMENT DISBURSEMENT AUTHORIZATION

| PRINT LAST NAME | STAFF IF YOUR HEALTH | CARE NEED |
|--|--|---|
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| FACILITY NAME | 1 Laces | DOO NOWIBER |
| , | HOUSING UNIT | 120039 |
| CBC(| SCH FEI | TODAY'S DATE |
| COPAYMENT DISBURSEMENT REQUEST AGREEMENT BY PATIENT | | 4-200 |
| | SECTION | |
| I understand the following: The Department of Communication | | |
| I will not be denied care if I am unable to pay the By signing below. Lam initiating a result of the pay the | payment of \$7.50 for a visit (face to face | Contact) initial |
| By signing below, I am initiating a request for dist | Copayment | contact) initiated by a patient when a copayment is required. |
| Failure to sign below will NOT prevent the copayr PATIENT SIGNATURE | ment from being withdrawn from my see | contact) initiated by a patient when a copayment is required. It at the time of the visit when a copayment is required. |
| ATIENT SIGNATURE | g manadam nom my acco | unt following a visit when a copayment is required. |
| | | |
| TO BE COMPLETED BY HSU ONLY | | |
| MEDICAL (Nurse, Doctor/NP/PA) | | |
| Charge Copayment: Yes No | ☐ DENTAL ☐ OPTICA | L Company of the Co |
| AUTHORIZED STAFF SIGNATURE | , | |
| - | | DATE OF SERVICE |
| O BE COMPLETED BY | | · · · · · · · · · · · · · · · · · · · |
| O BE COMPLETED BY INMATE PATIENT - He sure to include today's date on top of form. Check the | EALTH SERVICE REQUEST SECT | TION |
| mpleted form in the sick call box. The teach to | he appropriate box below and overlain | our request on the lines provided. Place all 4 pages of the equest has been received. |
| The HSU will send | a conv back to below, and explain yo | our request on the lines and it. |
| HEALTH SERVICES - | a copy back to you indicating that your r | equest has been received. Place all 4 pages of the |
| T DOVOLULE | RECORD REVIEW | equest has been received. |
| PSYCHIATRIST PLINFORMATION | RECORD REVIEW COPIES | equest has been received. S FROM HEALTH CARE RECORD (List records below) |
| PSYCHIATRIST HINFORMATION | RECORD REVIEW COPIES | S FROM HEALTH CARE RECORD (List records below) |
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