Department of Corrections
WASHINGTON STATE

PATIENT REQUEST FOR OUTSIDE HEALTH SERVICES

TO BE COMPLETED BY PATIENT		
Name	DOC#	Facility and Unit
Service Requested		
Service Provided By (Name and Address)		

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.

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

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

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.

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.

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)**.**

Signature	DOC Number	Date

Send the completed form to your facility Health Services Manager

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