Request for Authorization for KYDOC-State Inmates

KY DOC Inmate Number:		**Date of Service:**
Jail or Detention Center:		
Address:		**Phone:**
Requestor Email:		**Fax:**
Patient Name: (First)	**(Middle)**	**(Last)**
DOB:	**SSN #:**	**Gender: □ Male | □ Female**
Requesting Provider:	**Provider Signature:**	

Service:

Surgery provider (Hospital & Physician name):

Diagnosis:

Previous treatment and response (Include medications):

History of Illness/Injury with date of onset:

Results of complaint directed physical exam with findings:

Procedure or surgery requested:

Current functional ability/ADLs:

Other:

Please allow at least 72 hours prior to appointment for authorization to be completed.
DO NOT SEND COPIES OF PATIENT'S MEDICAL RECORDS!