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| **Initial JDC Service Request Form** |
| **Facility Name\*** |  | Please use all upper case |
| **DoH License No.\*** |  | Use upper case with no space |
| **Region\*** |  |  |
| **Type of Request\*** |  |  |
| **Facility Type\*** |  |  |
| **Dental\*** |  |  |
| **Self Pay activities\*** |  |  |
| **Facility Setting\*** | [ ]  OP | [ ] Inpatient | Note: Hold the CTRL key and click the items for multiple options |
| [ ]  ER | [ ]  Telemedicine |
| [ ]  Home Care | [ ]  Rehab-Outpatient |
| [ ]  Day Case | [ ]  Long-term Care |
| **E/M Guidelines used\*** |  |  |
| **Type of Medical Records\*** |  |  |
| **TRN No.\*** |  |  |
| **Title** |  |  |
| **Complete Name** |  | Audit Representative |
| **eEmail\*** |  |  |
| **Secondary Email** |  |  |
| **Mobile** |  |  |
| **Phone\*** |  |  |
| **Description** |  |  |