|  |  |  |
| --- | --- | --- |
| **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** |  | |  |