Statewide Misdemeanant Confinement Program
Out of Jail Medical Service Form

Please complete the following information to be reimbursed for mileage and personnel hours associated with out of jail medical services for an SMCP inmate.
Fax or email this completed form to
(866) 815-3409 or **SMCP@ncsheriffs.net**.

Date (MM/DD/YYYY): _____ Sheriff's Office: _____

Contact Person: _____

Telephone:_____ Email: _____

Inmate Information

Name: _____ _____ _____ _____
First Name Middle Name Last Name Suffix

RTN: _____

Date of Birth (MM/DD/YYYY): _____

Medical Service Information

Medical Facility Name: _____

Address: _____

City: _____ Zip code: _____

Date(s) of service: _____ to _____

Personnel hours: _____ Mileage (roundtrip):_____

Have you contacted Government Risk Solutions (GRS) to start the claim process? ◯ Yes ◯ No
(If you have not contacted GRS please follow the instructions found on your Subscriber Identification Card to begin this process.)

Additional Information: _____

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