LOUISIANA CRIME VICTIMS REPARATIONS BOARD
APPLICATION FOR HEALTHCARE PROVIDERS OF SERVICES TO VICTIMS OF SEXUALLY-ORIENTED CRIMINAL OFFENSES

Office: (225) 342-1749 Nationwide Toll-Free (888) 6-VICTIM www.lcle.la.gov/cvr

Date Application Received ________________________ CVR #______________________________

THIS BOX IS TO BE COMPLETED BY THE CVR OFFICE.

This application must be filled out completely then signed by an authorized representative of the healthcare provider AND the victim.
PLEASE PRINT! Applications must be filed within one year of the date of the crime.

VICTIM INFORMATION

Name: (First, Middle, Maiden and Last) ____

Complete Mailing Address: ____

Date of Birth: ____________________ Social Security #: ________________________ Date of Crime: ______________________

Did the alleged offense occur in Louisiana? ____________ What Parish did the offense occur in? ______________________________

If you are unsure what Parish the offense occurred in, please provide the name of the city. ____________________________________

STATISTICAL INFORMATION

Sex (Please circle.)	Victim's Age **at Time of Crime**	Ethnic Background (Please circle.)
Male Female	______________	Black American Indian Asian White Hispanic Alaskan Native

If the victim chose to file with his/her insurance company, please complete the following insurance information:

Company Name ____ Phone ______________________

Policy Number ______________________________________ Group Number ________________________

Address ____

(Street, City, State, & Zip Code)

Was the patient a victim of a sexually-oriented criminal offense? ____Yes ____ No

If victim is a minor/vulnerable adult, was sexual assault reported to law enforcement? ____ **Yes** ____ **No**

If yes, what specific agency? ____

Any other injuries the victim sustained? (Please include hospital notes.) ____________________________________

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LIST ALL EXPENSES. Attach current itemized bills, and EOBs if applicable, for each charge listed below.

Provider Name	Total Charge (+)	Collateral Payments (-)	Paid by Claimant (-)	Owed to Providers (=)

On behalf of the healthcare provider, I authorize the Crime Victims Reparations Board to review this application in accordance with R.S. 46:1802. I agree and certify that no person shall incur any legal liability to me by releasing any information pursuant to this authorization. A photocopy or exact reproduction of this signed release shall have the same force and effect as the original. I understand that willfully and knowingly providing false information could result in a fine or imprisonment. I certify subject to penalty of law that all information submitted with this application is correct and true to the best of my knowledge and that losses to be claimed are a direct result of the crime.

Healthcare Provider Name: (Hospital, Clinic, etc.) ____

Complete Mailing Address: ____ FEI #:__________________

Contact Name: ________________________________ Phone #: __________________ Fax #: __________________

E-Mail Address: ______________________________________ Job Title: ______________________________

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SIGNATURE OF AUTHORIZED PROVIDER: Date

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SIGNATURE OF VICTIM/PARENT/LEGAL GUARDIAN Date

PLEASE SEND THIS FORM AND REQUIRED ATTACHMENTS TO THE CRIME VICTIMS REPARATIONS BOARD OFFICE:
LCLE/CVR, P.O. Box 3133, Baton Rouge, LA 70821

Revised: January 30, 2019