CLAIM FORM FOR MEDICAL EXPENSES

OVERFLOW SHEET

THIS FORM IS TO BE COMPLETED BY THE CLAIMANT

Victim Name: _____ CVR NUMBER: _____

Claimant Name: _____

Your claim investigator is: _____ Phone: _____

NOTE: Neither the CVR Board nor the Sheriff's office is responsible for your bills.

Neither the Board nor the Sheriff's office is to be listed as the guarantor on the invoice or statement.

STEP 2. OVERFLOW:

LIST ALL EXPENSES. Include **itemized** bills from the hospital, doctor, ambulance, dentist, pharmacy, funeral home, cemetery, etc. Do **not** include bills paid in full by your insurance company. **Do not write "SEE ATTACHED."**

Provider Name	Total Bill +	Ins. Pmts/Ins. Adj, Other Pmts. -	Amount paid by Claimant -	Amount Owed to Providers =

YOU MUST ATTACH A COPY OF THE ITEMIZED BILL **AND** INSURANCE SETTLEMENT FOR EACH EXPENSE CLAIMED.

FOR MEDICAL MILEAGE: Identify medical provider, dates you visited, and miles round trip. The dates listed below must correspond with the documentation listed above. Only include trips that were 20 miles or more one-way.

NAME OF MEDICAL PROVIDER	DATES OF VISITS	MILES/ROUND TRIP
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

STEP 3. CLAIMANT SIGNATURE: _____

PRINT NAME: _____

DATE: _____

SEND THIS FORM AND REQUIRED ATTACHMENTS TO YOUR SHERIFF'S CLAIM INVESTIGATOR.

Revised: August 13, 2014