MEDICAL CLAIMS FOR VICTIMS OF SEXUAL ASSAULT

The following must be included in order to file a claim for medical payment(s) or reimbursement:

1. **Claim Form for Medical Expenses**
   a) **Form must be completely filled out and signed by the claimant.**
   b) **NOTE: VICTIMS OF SEXUAL ASSAULT ARE NOT REQUIRED TO FILE WITH PRIVATE INSURANCE IN ORDER TO RECEIVE ASSISTANCE FROM CRIME VICTIMS REPARATIONS. However, if insurance is used, the insurance information must be completely filled out on the Medical Expenses Claim Form and the Medical Verification Form.**

2. **Medical Verification Form - must be completed and signed by provider.**

3. **Invoice(s)**
   a) **Make sure all invoices list the provider name, address and phone number.**
   b) **Check dates of service to make sure they are dated *on the day of the crime or after* and that the victim is listed as the patient. (We actually do get invoices from time to time dated before the crime date or for another member of the family!)**
   c) **Please send in an up-to-date invoices. This will show any claimant payments, insurance payments or adjustments, as well as any write-offs that the provider has given. We cannot pay on "Balance Forward" statements or statements from collection agencies.**

4. **Receipts**
   a) **To be reimbursed for out-of-pocket expenses, the person listed on the receipt must be the claimant.**
   b) **Receipts should be on official paper (not out of a generic receipt book). If that is impossible, please submit an updated statement that shows the payment(s) that have been made.**

5. **To claim medical mileage, documentation showing the provider visits must correspond with dates being claimed for mileage. In order to claim mileage expenses, trips must be 20 miles or more each way. Also, please include a printout of mileage. (Mapquest, Google, etc.)**

*** **Information on the Claim Form MUST correspond with the Medical Verification Form AND with the itemized invoices/statements.**

AMBULANCE CHARGES
VICTIMS OF SEXUAL ASSAULT

Ambulance charges must be recorded on the Claim Form For Medical Expenses. These charges are divided into two categories:

Ambulance Transport **includes the base transportation charge and all of the mileage charges. The CVR Board pays a maximum of $300 for ground transport and $500 for air transport.**

Medical Expenses **includes all charges on the ambulance itemized invoice other than the** ***Ambulance Transport*** **charges. These will be paid at 100%.**

CLAIM FORM FOR MEDICAL EXPENSES
VICTIMS OF SEXUAL ASSAULT

THIS FORM IS TO BE COMPLETED BY THE CLAIMANT

CVR NUMBER: _____ Victim Name: _____

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 1. ANSWER THESE QUESTIONS ABOUT YOUR EXPENSES.

1. A. Are you responsible for any of these bills? [ ] Yes [ ] No, then who?_____
   B. If not, have you paid all or part of them anyway? [ ] Yes [ ] No
   NOTE: If you answered NO to questions 1A or 1B; stop here. You cannot submit a claim for this expense.
   If you answered YES to either question, please continue.
2. **NOTE: If you are a victim of sexual assault, you are not required to file with your insurance company in order to receive assistance from Crime Victims Reparations. However, if you choose to file with your insurance company,** please complete the following insurance information.
3. Attach a Medical Verification Form completed and signed by each provider listed below.

Have you chosen to file with your insurance company? ____ Yes ____ No ____ I have no insurance.

Company Name _____ Phone _____

Policy Number _____ Group Number _____

Address _____
(Street, City, State, & Zip Code)

STEP 2. LIST ALL EXPENSES. Include **current itemized** bills from the hospital, doctor, ambulance, dentist, pharmacy, etc. for each provider listed below. Do **not** include bills paid in full by your insurance company.

Provider Name	Total Bill +	Collateral Payments -	Amount paid by Claimant -	Amount Owed to Providers =

YOU MUST ATTACH A COPY OF EACH ITEMIZED INVOICE/STATEMENT **AND, IF YOU *CHOOSE* TO FILE WITH YOUR INSURANCE,** YOU **MUST** ATTACH YOUR INSURANCE PAYMENT/DENIAL EXPLANATION OF BENEFIT (EOB) 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: October 28, 2014

CRIME VICTIMS REPARATIONS
MEDICAL EXPENSE VERIFICATION FORM

THIS FORM IS TO BE COMPLETED BY PROVIDER'S BUSINESS OFFICE

CVR NUMBER:

VICTIM:

VICTIM SSN:

CLAIMANT:

DATE OF CRIME:

Sheriff's Claim Investigator:

Address:

Phone:

CLAIM INVESTIGATOR INSTRUCTIONS:
1) This form may be sent in lieu of phone verification of medical expense.
2) Send a copy of this form and the "Authorization To Release Information" to each medical provider listed on the claim form.
3) Attach the completed verification form(s) to the claim form before forwarding to the CVR Board Office.

MEDICAL PROVIDER INSTRUCTIONS:
1) This form is to be completed by the business office.
2) A Crime Victims Reparations claim has been made under the Louisiana Crime Victims Reparations Act LA R.S. 46.1801-1822 by the above-named victim for injuries sustained on the date shown.
3) The completed form is to be returned to the sheriff's Claim Investigator at the address shown.
4) Neither the Louisiana Crime Victims Reparations Board nor the Sheriff's Office acts as guarantor for any service rendered.
5) **NOTE: IF THE PATIENT IS THE VICTIM OF SEXUAL ASSAULT, HE/SHE IS NOT REQUIRED TO FILE WITH HIS/HER INSURANCE IN ORDER TO RECEIVE ASSISTANCE FROM CRIME VICTIMS REPARATIONS. However, if he/she chooses to file with insurance, the insurance information must be completed below.**

TOTAL CHARGES FOR SERVICE TO DATE: $ _____

IF PAID BY PATIENT: _____

PAID BY INSURANCE: _____

ANY INSURANCE ADJUSTMENTS: _____

OTHER PAYMENTS(EXPLAIN ON BACK): _____

CURRENT BALANCE: $ _____

TYPE OF SERVICE:

☐ HOSPITAL ☐ IN-PATIENT

☐ PHYSICIAN ☐ OUT-PATIENT

☐ DENTAL ☐ OTHER

ACCOUNT NUMBER(S) _____

DATE(S) of SERVICE _____

NAME AND ADDRESS OF PATIENT'S INSURANCE: **(SEE INSTRUCTION #5 ABOVE) (VOLUNTARY)**

_____

_____

_____

POLICY NUMBER: _____

GROUP NUMBER: _____

PHONE NUMBER: _____

NAME AND ADDRESS OF POLICY HOLDER: _____

_____

IF THE PROVIDER IS A HOSPITAL, ATTACH THE FOLLOWING DOCUMENT(S) TO THIS FORM:
ITEMIZED STATEMENT, EMERGENCY TREATMENT AND FINAL DISCHARGE REPORT

_____
AUTHORIZED SIGNATURE

_____
PRINTED NAME

_____
TITLE

_____
DATE PHONE

_____
BUSINESS NAME

_____
ADDRESS

_____
CITY, STATE, ZIP

_____
FEDERAL EMPLOYER IDENTIFICATION NUMBER

Revised: October 28, 2014