MEDICAL CLAIMS

Medical Expenses are paid to providers up to 70%. Out of pocket expenses are paid at 100%. 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) **Insurance information must be completely filled out. If victim has no insurance, write "NONE" in the space for "Company Name."**

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

3. **Invoice(s)**
   a) **Make sure all invoices have the provider name, address and phone number on them.**
   b) **Check dates of service to make sure they are dated *on the day of the crime or after* and that the victim is actually the patient. (We actually do get invoices from time to time dated before the crime date or for another member of the family!)**
   c) **If the invoice is old, try to get an up-to-date one. This will show any claimant or insurance payments 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, get an updated statement that shows the payment(s) that have been made.**

5. **If the victim had insurance, the insurance payment should be included on the provider statement. If the insurance denied payment, please include the insurance Explanation of Benefits (EOBs) explaining why the claim was denied.**

6. **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 one-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 invoices/statements.**

AMBULANCE CHARGES

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

Ambulance Transport -- this 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 – this includes all other charges on the ambulance itemized invoice once the base transportation charge and mileage charges have been subtracted out. This is paid at the normal percentage up to 70%.

CLAIM FORM FOR MEDICAL EXPENSES

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. Complete the following information for all insurance and/or benefit plans which might cover these expenses. If you have no insurance, please write "None" for company name.
3. Attach a Medical Verification Form completed and signed by each provider listed below.

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 **+**	Ins. Pmts./Ins. Adj. and Other Pmts. **-**	Amount paid by Claimant **-**	Amount Owed to Providers **=**

YOU MUST ATTACH A COPY OF THE ITEMIZED BILL **AND** INSURANCE PAYMENT/DENIAL 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: June 26, 2024

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 and checklist 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 at 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) Insurance payments must be credited before completion of this form.

TOTAL CHARGES FOR SERVICE TO DATE: $ _____

PAID BY PATIENT: _____

PAID BY INSURANCE: _____

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:

_____

_____

_____

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: June 26, 2024

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.