Medical Service Treatment Plan Form

Crime Victim Compensation
Seventeenth Judicial District
1000 Judicial center drive, suite 100
Brighton, CO 80601

Crimevictimcompensation.org
Phone: 303-835-5615
Fax: 303-835-5575

Prior approval for crime related medical treatment and/or submission of this form does not guarantee payment of additional medical services. You will be notified by mail of all Board decisions. All treatment costs exceeding the approved amount determined by the Board are the responsibility of the claimant. This form may be emailed to you for convenience. Handwritten forms will not be processed and will be returned.

Provider Information
Name/Practice Name:_____
Business Address:_____
City/State/Zip: _____
Telephone Number:_____
Fax Number:_____
Email:_____

Client/Claimant Information:
Name: _____
Address:_____
City/State/Zip: _____
Telephone Number:_____

Please indicate what type of services this treatment plan includes:

___Surgery ___Chiropractic Care ___Physical Therapy
___Occupational Therapy ___Massage Therapy ___Other_____

1) Will your client's private insurance cover your services? _____

If not, please write N/A next to the insurance information below. If so, C.R.S. §24-4.1-110 requires that Victim Compensation funding be used as a last resort. Thus, it is required that providers bill the insurance company first. Then, figure out the co-payment amount or amount that will not be covered and write your treatment plan request accordingly. If approved, you will be paid at 80% of the total balance billed after insurance has made payment.

Insurance Information
Company:_____
Fax Number: _____
Group Number:_____

Telephone Number:_____
Policy Number:_____

2) Briefly, describe the injuries of your patient, how they were caused by the crime:

3) Was the client a patient of yours before the criminal incident? If so, how might you differentiate the pre-existing symptoms from those related to the crime?

4) List the treatment and objectives relative to the victimization. Each goal should have an estimated completion date.

5) Describe any issues that may increase or decrease the length of treatment or effectiveness of services provided.

6) Date client entered treatment: _____

   Number of visits or services provided to date: _____

7) Anticipated number of visits/sessions per week/month of on-going treatment: _____

   Anticipated number of weeks or months of treatment: _____

8) Regular fee for itemized services: The Board will not consider a treatment plan without an estimated cost of services:

9) Are there services which will be billed by another provider (ex. Anesthesia)? Please list those services:

Once the Board has made an approval you will be notified via mail. The Board processes and issues payments only once a month, therefore payment could take up to 30 days after receiving an itemized bill/invoice. The Compensation Board makes payment towards medical bills at 80% of the balance due (after insurance). We ask that you accept our payment as payment in full. If not, please inform the patient that they will be responsible for any remaining balance.

_____ _____

Provider Signature **Date**

_____ _____

Patient/Claimant Signature **Date**