Victim Compensation Board
Department 5031
P.O. Box 20,000
Grand Junction, Colorado, 81502

Telephone: 970-244-1737
Fax: 970-256-1549

21ST JUDICIAL DISTRICT
CRIME VICTIM COMPENSATION BOARD

MEDICAL/DENTAL SERVICE TREATMENT PLAN FORM

Prior approval for crime related medical/dental treatment and/or submission of this form does not guarantee payment of additional medical/dental services. You will be notified in writing 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. Hand written 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:

☐ Acupuncture ☐ Chiropractic Care ☐ Dental Reconstruction ☐ Massage Therapy
☐ Neurological Testing ☐ Occupational Therapy ☐ Surgery
☐ Other: _____

1. **Will your client's private insurance cover your services?** ☐ No ☐ Yes

   If not, leave the insurance information below blank. 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 of amount that will not be covered and write your treatment plan request accordingly. If approved, you will be paid at 100% of the total balance billed after insurance has made a payment.

   Insurance Information:

   Policy Holder: _____

   Company Name:_____

   Policy Number: _____ Group Number: _____

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

3. **Was the client a patient of your 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/sessions provided to date: _____
   Anticipated number of visits/sessions per week/month of on-going treatment: _____
   Anticipated number of weeks or months of treatment: _____

7. **Regular fee for itemized services (the Board will not consider a treatment plan without an estimated cost of services):**
   $_____ please attach an itemized estimate.

8. **Are there services which will be billed by another provider (ex. Anesthesia)?** ☐ No ☐ Yes
   If 'Yes', please list those services:

Once the Board has made an approval you will be notified in writing. 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 100% of the balance due (after insurance) and at 80% of the balance due for those without 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