21ST JUDICIAL DISTRICT
CRIME VICTIM COMPENSATION BOARD

MEDICAL/DENTAL SERVICE TREATMENT PLAN FORM

Victim Compensation Board
Department 5031
P.O. Box 20,000
Grand Junction, Colorado, 81502
Telephone: 970-244-1730
Fax: 970-256-1432
Email: victims.comp@mesacounty.us

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.

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 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 Victim Compensation Board makes payment towards medical/dental bills at 100% of the balance due. 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