CLAIM FORM FOR MEDICAL EXPENSES

VICTIMS OF SEXUAL ASSAULT

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. NOTE: IF YOU ARE A VICTIM OF SEXUAL ASSAULT, YOU ARE NOT REQUIRED TO FILE WITH YOUR INSURANCE IN ORDER TO RECEIVE ASSISTANCE FROM CRIME VICTIMS REPARATIONS. Include **itemized** invoices/statements from the hospital, doctor, ambulance, dentist, pharmacy. Do **not** include bills paid in full by your insurance company. **Do not write "SEE ATTACHED."**

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

YOU MUST ATTACH A COPY OF THE ***ITEMIZED*** INVOICE/STATEMENT 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.