

# CLAIM FORM FOR MEDICAL, MENTAL HEALTH & FUNERAL EXPENSES

**THIS FORM IS TO BE COMPLETED BY THE CLAIMANT**

CVR NUMBER: \_\_\_\_\_ Victim Name: \_\_\_\_\_  
 Claimant Name: \_\_\_\_\_  
 Your claim investigator is: \_\_\_\_\_ Phone: \_\_\_\_\_

**Note: The CVR Board is not responsible for your bills. The Board is not to be listed as the guarantor on the bill.**

**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.

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, funeral home, cemetery, etc. Do **not** include bills paid in full by your insurance company.

Provider Name	Total Bill	Amount paid by Insurance	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, MILES ROUND TRIP  
 (The dates listed below must correspond with the documentation listed above.)

NAME OF MEDICAL PROVIDER	DATES OF VISITS	MILES/ROUND TRIP
_____	_____	_____
_____	_____	_____

SEND THIS FORM AND REQUIRED ATTACHMENTS TO:

**STEP 3. SIGN HERE** \_\_\_\_\_  
 DATE \_\_\_\_\_