Psychiatric Evaluation/ Medication Treatment Plan Form

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

Phone: 303-835-5615
Fax: 303-835-5575

Prior approval for mental health counseling, psychiatric evaluations or medication consults and/or submission of this form does not guarantee payment of additional psychiatric 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:

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 purpose of the evaluation as it relates to the victimization and your diagnosis?

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? If no, do you believe there are pre-existing conditions?

4) List the treatment goals 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) How many times per week or month do you plan to see your patient?

   Anticipated number of weeks or months of on-going treatment:

8) Regular fee for evaluations and medication consultations (the Board will not consider a treatment plan without an estimated cost):

9) Identification of medications being prescribed and anticipated length of prescription:

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**