NEBRASKA CRIME VICTIM'S REPARATIONS
MEDICAL PROVIDER CLAIM FOR COMPENSATION

In order to process a medical provider claim for compensation, the following information is needed:

1. The following **Claim for Compensation** must be thoroughly and accurately completed.
2. The **Release of Information** must be signed and dated by the victim/survivor.
3. The **Attestation** must be completed, signed, and if applicable, a copy of the corresponding USCIS documentation submitted with the application.
4. Fully **itemized billing statement(s)** corresponding to the expenses being claimed must be submitted with the completed claim form.
5. **Documentation substantiating that all other payor sources** have been exhausted must be submitted with this completed claim form.

Who is eligible for compensation benefits?

- This application is only for victims of sexual assault, domestic violence, or child abuse

The Nebraska Crime Victim's Reparations (CVR) Program is the payor of last resort. Any medical or mental health benefits available to the applicant must be utilized prior to CVR. These include insurance, Medicaid, Medicare, or hospital/facility financial assistance.

Expenses related to a Forensic Medical Exam are not eligible and should only be submitted to the Sexual Assault Payment Program. For questions related to the Sexual Assault Payment Program, email **ncc.sapp@nebraska.gov.*

CVR Program Requirements:

- The crime must have taken place in the state of Nebraska
- The claim must be received by the CVR program within two (2) years of the date of the crime
- The incident must have been reported to law enforcement within three days

UNLESS

*** The application is by/for a victim of sexual assault, domestic assault, child abuse or sex trafficking - and if prior to submitting the application:

  - The victim/survivor reported to law enforcement
  - The victim/survivor obtained a protection order related to the incident
  - The victim/survivor has presented for a forensic medical exam

How do I submit a Medical Provider Application?

- Submit the application and applicable documentation to:
  - **NCC.CVRMedical@nebraska.gov**

Parameters

- Per the CVR Committee, the amount eligible for reimbursement is up to $5,000.00
- Per the CVR Committee, the amount submitted for consideration can only be billed at the Medicare/Medicaid rate
- By submitting a CVR Medical Claim and accepting compensation award payment, the medical provider shall hold harmless the victim/survivor for any amount not collected that is more than the awarded amount.

NEBRASKA CRIME VICTIM'S REPARATIONS
MEDICAL PROVIDER APPLICATION

Nebraska Crime Victim's Reparations Program
PO Box 94946
Lincoln, NE 68509-4946
P 402.471.2828
F 402.471.2837
ncc.cvrmedical@nebraska.gov

Section 1: Medical Provider Information		
Medical Provider/Agency		**Tax ID Number**
Name of Submitter	**Submitter Email**	**Submitter Phone**

Section 2: Victim Information			
Victim Full Name			**Victim SSN**
Address		**City & State**	**Zip**
Telephone Number	**Date of Birth**	**Sex of Victim** ☐ **Male** ☐ **Female** ☐ **Other**	
Occupation at Time of Crime ***(****if unemployed, enter "UNEMPLOYED"****)***		**Place of Employment at Time of Crime** *(Enter "N/A" if unemployed)*	
Marital Status		**If Married, Spouse's Name**	

Federal Civil Rights Information:

To comply with Federal regulations, The Department of Justice requires us to collect the following data. This information is used for statistical purposes only and will remain confidential.

This information relates to the victim only.

Ethnic Group:

☐ **American Indian/Alaska Native** ☐ **Asian** ☐ **Black/African American** ☐ **Hispanic/Latino**

☐ **Native Hawaiian/Other Pacific Islander** ☐ **White Non-Latino/Caucasian** ☐ **Some Other Race**

Country of Birth: _____

COMPLETE INFORMATION ON NEXT PAGE

Was the victim disabled prior to this crime? ☐ Yes ☐ No	Is the victim disabled as a result of this crime? ☐ Yes ☐ No

Section 3: Claimant Information

If this claim is being completed for a victim who is deceased, incapable, or a minor under age 18

Claimant Full Name		Claimant SSN
Address	City & State	Zip
Telephone Number:	Date of Birth	Sex of Claimant ☐ Male ☐ Female ☐ Other
Occupation	Place of Employment	
Relationship to Victim ☐Spouse ☐Parent ☐Child ☐Other (*Explain*):		

Section 4: Crime Information

Date of Crime	Place of Crime
Crime Type ☐ Sexual Assault ☐ Domestic Violence ☐ Child Abuse	Law Enforcement Agency

Section 5: Collateral Resources

Does the victim have coverage or benefits available from any of the following? Check all applicable boxes.

☐ Health Insurance ☐ Medicaid ☐ Medicare ☐ Facility Financial Assistance ☐ Other (*specify below*)

Health Insurance Company Name	Policy Number
Medicaid	Medicaid Number
Medicare	Medicare Number
Facility Financial Assistance	Financial Assistance Number
Other	Other

COMPLETE INFORMATION ON NEXT PAGE

Nebraska Crime Victim's Reparations Program Authorization to Release Information

This authorization is an integral part of your application and must be **signed and dated by the victim/claimant** before any action will be taken on your claim.

About the Nebraska Crime Victim's Reparations (CVR) Program: The CVR program assists eligible victims of crime who suffer bodily harm and have incurred a financial loss as a direct result of a criminal act. You are eligible for potential payment of your related medical expenses if you are a victim who suffers bodily injury from a crime, a dependent or legal representative of a victim, a parent/guardian responsible for a minor's medical expenses, or if you are injured while aiding a crime victim or assisting a police officer. The CVR program will not pay for loss of property, pain and suffering, indirect expenses, and expenses paid by your insurance company or other payor sources (such as workers' compensation). **In order for the CVR program to consider payment of your medical expenses, you must report the crime to law enforcement within three (3) days of the incident.***

AUTHORIZATION TO RELEASE INFORMATION

☐ I hereby authorize _____ to furnish to the CVR program or its representative, confidential information with respect to the incident leading to my personal injury or death and any other information required by the CVR program for the purpose of payment of my medical expenses. Per 45 CFR 164.506, the CVR program is a potential payor and this Authorization to Release Information will be used to determine eligibility for the purpose of adjudicating claims for payment. A photocopy of this document is as effective and valid as the original. I have the right to revoke this authorization at any time, except where _____ has already acted in reliance on my authorization. Revocation must be submitted in writing to _____. Unless otherwise revoked, this authorization will expire one (1) year from the date signed below. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization. Any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

*** To include hospital, physician, medical facility or medical provider that attended or examined the victim.**

☐ I furthermore understand that any recovery of my losses through restitution/reimbursement from the offender, a civil suit, insurance or from any other governmental or private agency shall entitle the Nebraska Crime Victim's Reparations program to be reimbursed for any compensation awarded me by the Nebraska Crime Victim's Reparations program. The undersigned swears or affirms the information contained herein is true to his/her best knowledge. **I understand that the filing of false information is an offense punishable by law**.

☐ I understand I have the ability to submit a claim directly to the Crime Victim's Reparations (CVR) program for medical expenses incurred from additional providers as a result of this incident, as well as Loss of Wage and/or Mental Health Expenses.

☐ I hereby decline to release the medical provider to apply directly to the CVR program on my behalf. I understand it is within my discretion as a survivor to determine how potential compensation available to me is pursued.

_____ _____

Victim or Claimant Signature
(Parent/Guardian if victim/claimant/dependent is a minor)

Victim or Claimant Printed Name
(Parent/Guardian if victim/claimant/dependent is a minor)

_____

Date

Enter in blank space(s) provided the specific Medical Provider Agency Information as well as the Medical Agency's Address for Revocation Submission.

COMPLETE INFORMATION ON NEXT PAGE

UNITED STATES CITIZENSHIP ATTESTATION

For the purpose of complying with Neb. Rev. Stat. §§ 4-108 through 4-114, I attest as follows:

☐ I am a citizen of the United States.

-OR-

☐ I am a qualified alien under the federal Immigration and Nationality Act **AND** I agree to provide a copy of my USCIS documentation. (Enter Immigration Status and Alien Number below)

My immigration status is: _____

My alien number is: _____

I hereby attest that my response and the information provided on this form and any related application for public benefits are true, complete, and accurate and I understand that this information may be used to verify my lawful presence in the United States.

PRINT NAME: _____
(First, Middle, Last)

SIGNATURE: _____

DATE: _____

COMPLETE INFORMATION ON NEXT PAGE