DENTAL TREATMENT FORM

A Division of the Virginia Workers' Compensation Commission

Web: www.virginiavictimsfund.org · Mail: P.O. Box 26927, Richmond, Virginia 23261 · Phone: 1.800.552.4007 · Fax: 804.823.6905

In order to consider expenses for dental treatment, the Fund expects treatment to be performed by a licensed provider according to the Code of Virginia § 54.1-2716, directly related to the crime incident, and reasonable and appropriate. Consideration of treatment will be given upon the provider's completion of this Dental Treatment Form. If there is a gap in treatment, additional documentation may be requested at the time of future treatment. Failure to receive prior approval may result in the denial of payment. Additional information may be requested by the Fund on a case-by-case basis.

DATE OF SERVICE: **VVF CLAIM NO.**

PATIENT'S FULL NAME: **PARENT/LEGAL GUARDIAN**:

BRIEF DESCRIPTION OF TREATMENT:

INSURANCE

Is the patient covered by any health insurance? Yes No (if yes, please provide a remittance with the itemized billing statement)

Do you accept the patient's form of health insurance, if available? Yes No

In accordance with § 19.2-368.3 of the Code of Virginia, health care providers must establish negotiated rates for payment of claims administered through the Virginia Victims Fund (VVF). A Memorandum of Agreement (MOA) will be mailed under separate cover.

TREATMENT INFORMATION

Is the treatment a *direct* result of the crime that occurred on ? Yes No (if no, provide additional explanation)

I certify, under penalty of fraud, that the services listed in the attached itemized statement and provided to Virginia Victims Fund are a direct result of a crime against the patient/victim and respectfully submit the expenses listed in the statement for payment by Virginia Victims Fun.

I understand that this form is being accepted for payment consideration in lieu of full records, dental notes, etc. and is necessary for a determination of the Fund's ability to pay. I certify that all information contained above and within supplemental documentation is accurate and complete.

TREATMENT INFORMATION *(continued)*

I understand that I must provide an itemized billing statement of crime-related charges, inclusive of payments received, adjustments, and insurance payments/adjustments, before payment can be made by Virginia Victims Fund.

By signature of this form, I certify that all information contained above and attached is accurate and complete.

Provider Name *(please print)* Name of Practice

Mailing Address

Provider Signature Date

In order for Virginia Victims Fund to process a provider's expense, the Fund must be in receipt of this treatment form and an itemized billing statement of crime-related services rendered.

Documentation can be submitted to Virginia Victims Fund at the following:

Mail| Virginia Victims Fund, Post Office Box 26927, Richmond, VA 23261 **Fax|** 804-823-6905 **Email|** info@virginiavictimsfund.org