State of Nevada
Victims of Crime Program

Request for Pre-Authorization for Payment

Submit this form when requesting pre-authorization for payment for services to victim for any crime related expense

Victim/Patient Name:	VOCP Claim #

Service or Treatment Information:

Description of service or treatment: (include CPT and HCPCS codes) Attach Billing Documents.

What is the cost, or estimated cost of this service or treatment?

Is this service or treatment necessitated by the crime?
- ☐ Yes
- ☐ No If *No* please explain:

Is any portion of this covered by Insurance, or did the Applicant/Victim pay any portion of this claim?
- ☐ Yes If *Yes* please explain:
- ☐ No

The information provided herein is true and accurate to the best of my information and belief

Authorized Signature:	Print Signers Name:	Date:

Tele:	Fax:	E-mail:

Mail to: VOCP P O Box 94525 Las Vegas, NV 89193-1525	*Fax to:* (702) 458-5586	*Scan and email to:* applications@voc-net.com

VOCP Pre-Authorization for Payment for Treatment or Services:

This Authorization is only valid for 60 days after date approved by the Compensation Officer.

VOCP Decision: ☐ *Approved* ☐ *Denied*	*Amount Approved: $*	*Date CCSI Review:*
	Compensation Officer Signature**: **(Required for approval)	*Date:*