



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 #
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Service or Treatment Information:

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

What is the cost, or estimated cost of this service or treatment? (costs must be itemized by CPT codes)

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:	EIN:
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<i>Mail to:</i> VOCP P O Box 94525 Las Vegas, NV 89193-4525	<i>Fax to:</i> (888) 941-7890	<i>Scan and email to:</i> applications@voc-net.com
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VOCP Pre-Authorization for Payment for Treatment or Services:

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

<i>VOCP Decision:</i> <input type="checkbox"/> <i>Approved</i> <input type="checkbox"/> <i>Denied</i>	<i>Amount Approved: \$</i> <hr/> <i>Compensation Officer Signature: (Required for approval)</i>	<i>Date CCSI Review:</i> <hr/> <i>Date:</i>
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