



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) 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? No?

If *Yes* please explain:

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

Authorized Signature:	Print Signers Name:	Date:

Tele:	Fax:	Email:
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<i>Fax to:</i> (702) 486-2825	<i>Mail to:</i> VOCP 6171 W. Charleston Blvd., Bldg. 9 Las Vegas, NV 89146	<i>Scan and email to:</i> vocp@dcfs.nv.gov
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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>	<i>Amount Approved \$</i>	<i>Date CCSI Review:</i>
Approved Denied	<i>Compensation Officer Signature (Required for Approval)</i>	<i>Date:</i>