

**VIOLENT CRIMES COMPENSATION BOARD
MEDICAL INSURANCE FORM**

Claimant Name: _____

VCCB Claim No: _____

Victim Name: _____

Date of Incident: _____

TO QUALIFY FOR COMPENSATION YOU MUST ANSWER THE FOLLOWING QUESTIONS

Is the victim a minor?	Yes	No
Is the victim covered by someone else's insurance?		

If yes, whose? _____ Relationship to victim _____

Is the victim covered by: _____

	Yes	No	
Personal Health Insurance?			Name of Insurance
Employer Health Insurance?			Name of Insurance

TRICARE (CHAMPUS)?			Claim #
VA Benefits			Claim #
GRM?			Claim #

Medicaid?			Claim #
Medicare?			Claim #

Denali Kid Care?			Claim #
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Workman's Compensation?			Claim #
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(This applies if the incident in the claim occurred on the job.)

Other Insurance?			Name of Insurance
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If you answered yes to any of the questions above please complete the following:

Name of insured card holder	Insurance Co.	Address / Phone No.

Did the victim incur any of the following as a direct result of the incident?

	Yes	No	
Injury			What is the injury
Short term Disability			If so, how long?
Long term Disability			If so, how long?

If there are unpaid medical and / or counseling bills that you have paid, that were incurred as a direct result of the incident in your claim, please provide a complete list of all providers with names, addresses, telephone numbers, and dates of service.

The back of this form is provided for this purpose.

Violent Crimes Compensation Board
P.O. Box 110230
Juneau, AK 99811

Phone: 1-800-764-3040

Fax: 907-465-2379

Your signature here _____

THIS FORM MUST BE COMPLETED IN ITS ENTIRETY WITH ALL AREAS CHECKED.

