VIRGINIA VICTIMS FUND
Helping Innocent Victims of Crime
OFFICIALLY CRIMINAL INJURIES COMPENSATION FUND

MENTAL HEALTH TREATMENT REQUEST

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 counseling expenses reasonable and appropriate, the Fund expects treatment to be crime-centered and time-limited. The Fund considers reimbursement for those disorders specified in the Diagnostic and Statistical Manual of Mental Disorders V as Trauma- and Stressor-Related Disorders. **Outpatient mental health counseling shall be limited to forty (40) sessions per claim**, beginning on the date of the first counseling session. Sessions exclusively for the purposes of medication management will be counted in the 40-session limit. Consideration of treatment will be given upon the practitioner's completion of this **Mental Health Treatment Request** for up to forty (40) sessions contingent on the sessions being continual. If there is a gap in treatment, additional documentation will be requested at the time of future treatment. Sessions beyond forty (40) require prior approval from the Fund's Director. Failure to receive prior approval will result in the denial of subsequent sessions. Approval of additional sessions is contingent upon the rationale behind the need and details provided. Additional information may be requested by the Fund on a case-by-case basis.

Crime Date/Initial Date of Presenting Issue: **CICF Claim No.**:

Patient's Full Name: Parent/Legal Guardian:

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

TREATMENT INFORMATION

Date of Initial Session_________________ Type of Crime:

Is the trauma and treatment a *direct* result of this crime? Yes No *(if no, provide additional explanation)*

Brief description of the symptoms/conditions being treated that are a direct result of the crime:

Presenting Issue:

Chapter Diagnosis:

Description of the psychological trauma as related to the crime:

If medication has been prescribed, please provide the name(s) of medication (brand/generic) and symptoms for which medication was prescribed:

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TREATMENT PLAN

Based on the diagnosis and related symptoms, what are the specific treatment goals that have been set for the patient?

What are the treatment strategies to achieve these goals?

Anticipated Completion Date:

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

Provider Name *(please print)*

Provider License Type and Number

Name of Practice

Telephone No.

Mailing Address

City/State/Zip Code

Provider Signature

Date