STATE OF CALIFORNIA

MENTAL HEALTH BILLING INTAKE FORM

VCB-31-10018ab (New 11/2022)

Claimant Name: ______________________ CalVCB Application No.: ____________

Instructions: This form is required for claimants initiating treatment on or after December 15, 2022. Providers are required to submit a completed Mental Health Billing Intake Form with the claimant's first bill since CalVCB must verify that treatment is a direct result of the qualifying crime and there are no other reimbursement sources available.

If the explanation of benefits cannot be obtained and one of the exceptions listed below applies, the claimant can check the appropriate box and sign the Claimant Declaration page.

The Treatment Plan Form must also be completed in its entirety and kept in the claimant's file, except in the following circumstances when it must be submitted to CalVCB:

1. Upon CalVCB's request.
2. If the treatment is less than 100% related to the qualifying crime.
3. There was a delay in treatment of three years or break in treatment over of more than one year.
4. If the treatment is for a post-crime primary caretaker.
5. If the claimant was three years old or younger when treatment began.

Bills must be submitted within 90 days of each date of service provided. If multiple dates of service are included in one CMS 1500 form, then it must be submitted within 90 days from the first service date on the bill.

You only need to submit this completed form when submitting the first bill for each claimant.

Crime Date: ____________ Type of Crime *(brief description)*: ______________________

Treatment Information

Date Treatment Began: ____________ Date Treatment Terminated *(if applicable)*: ____________

Is treatment necessary as a direct result of the qualifying crime? ☐ Yes ☐ No

Mental Health Provider Information

Provider Organization Name: ______________________ Email: ____________

Treating Provider Name: ______________________ Phone Number: ____________

Supervising Provider Name *(if applicable)*: ______________________ Phone Number: ____________

Provider Declaration

Important: This document will not be accepted without the required signature(s) and date(s) below.

I acknowledge that CalVCB is the payor of last resort and can only pay for treatment that is not covered by any other reimbursement source. I further acknowledge that, pursuant to California Code of Regulations, Title 2, Section 649.28 (a), I shall be subject to a clinical or fiscal audit, or both, to ensure that treatment and reimbursement were authorized by law.

I declare under penalty of perjury under the laws of the State of California that: (1) I have read all of the questions contained on this form and, to the best of my knowledge and belief, all my answers are true, correct and complete; and (2) all treatment submitted for reimbursement by CalVCB or pursuant to this form was necessary as a direct result of the crime described above; and (3) I understand that action may be taken to recover benefits paid by CalVCB if I provide information that is false, intentionally incomplete, or misleading.

I certify that I am licensed to practice in *(state)*: __________ Treating Provider License Number: ______________

Treating Provider Signature: ____ Date: ____________________

I certify that I am licensed to practice in *(state)*: ____

Supervising Provider License Number *(if applicable)*: ____

Supervising Provider Signature *(if applicable)*: ______________________________ Date: ____________________

Billing Information (For Claimant to Complete)

For consideration of payment, submit an Explanation of Benefits (EOB) form for any paid/partially paid expenses or a copy of the denial statement for any denied expenses. If you are unable to provide an EOB, note the reason(s) by checking the applicable box(es) below and CalVCB may consider payment.

If Insurance or Medi-Cal cannot be billed, indicate reason below:

☐ Network provider is located more than 45 miles from claimant's residence.

☐ Network provider is not able to treat claimant within 45 days of request based on scheduling.

☐ Network provider has a limited number of Medi-Cal slots and all Medi-Cal slots have been filled.

☐ Other ____.

Claimant Declaration

I declare under penalty of perjury under the laws of the State of California that all the information I have provided is true, correct, and complete to the best of my knowledge and belief. I understand any potential reimbursement sources available will be billed to insurance and must be disclosed to CalVCB. I understand that I may be found to be ineligible for benefits, and that action may be taken to recover benefits I receive if I provide information that is false, intentionally incomplete, or misleading.

Adult Claimant/Guardian Name*: ____ Date: ______________

Adult Claimant/Guardian Signature*: ____ Date: ______________

**If the claimant is a minor with no parent or guardian, please contact CalVCB at the number below.*

CALIFORNIA VICTIM COMPENSATION BOARD

P.O. Box 3036 • Sacramento, CA 95812 • Phone: 800-777-9229 • www.victims.ca.gov

Información de Facturación (A Ser Completada por el Demandante)

Para considerar el pago, presente una Explicación de Beneficios (EOB) para cualquier gasto pagado/parcialmente pagado o una copia de la declaración de denegación de cualquier gasto denegado. Sin embargo, si usted no puede presentar una EOB, justifique la(s) razón(es) marcando la(s) casilla(s) a continuación para que el pago sea considerado.

Si no se puede facturar al Seguro o a Medi-Cal (Programa de Asistencia Médica de California), indique el motivo a continuación:

☐ El proveedor de la red está situado a más de 45 millas de distancia de la residencia del demandante.

☐ El proveedor de la red no puede atender al demandante en un plazo de 45 días posteriores a la solicitud según la programación.

☐ Mi terapeuta tiene un número de vacantes limitadas para Medi-Cal y todas las vacantes ya están llenas, o mi seguro es una OMS (Organización de Mantenimiento de la Salud) y mi terapeuta no pertenece a ningún panel de seguros.

☐ Otro ____.

Declaración del Demandante

Yo declaro, so pena de condena por falso testimonio de conformidad con las leyes del estado de California, que toda la información que he proporcionado es verdadera, correcta y completa a mi leal saber y entender. Entiendo que cualquier fuente potencial de reembolso disponible se facturará al seguro y debe ser divulgada a CalVCB (Programa de Compensación para las Víctimas de California). Entiendo que se puede determinar que no soy elegible para los beneficios, y que se pueden tomar medidas para recuperar los beneficios que recibo si proporciono información falsa, intencionalmente incompleta o engañosa.

Nombre del Demandante/Tutor Adulto*: ______________________________ Fecha: ________________

Firma del Demandante/Tutor Adulto*: ______________________________ Fecha: ________________

**Si el demandante es un menor de edad sin padre o tutor, contacte a CalVCB (Programa de Compensación para las Víctimas de California) a su número telefónico.*

For fastest service, upload document through your CalVCB Online account: https://online.victims.ca.gov/Home/ProviderInfo. Otherwise, you may send via fax: 866-902-8669 or postal mail: CalVCB, P.O. Box 942003, Sacramento, CA 94204-2003. For further assistance or information about how to create a CalVCB Online account, contact customer service at 800-777-9229.