## PLEASE RETURN TO THE LOCATION BELOW

**New York State**
**Office of Victim Services**
AE Smith State Office Building
80 South Swan Street, 2nd floor
Albany, NY 12210
(518) 457-8727

# ATTENDING PHYSICIAN'S REPORT

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|---|---|
| 1. NAME OF INJURED VICTIM (Last, first, middle) | 2. HOME MAILING ADDRESS (Number, street, city, state, zip code) |
| 3. DATE OF CRIME (Mo, day, year) | 4. DOES THE VICTIM HAVE MEDICAL COVERAGE?<br>☐ Yes ☐ No (If yes, which plan) |

5. WHAT HISTORY OF CRIME RELATED INJURY DID THE VICTIM GIVE YOU?

6. WHAT IS YOUR DIAGNOSIS (Include results of x-rays, laboratory tests, etc?)

7. DOES THE VICTIM HAVE A HISTORY OF A PRE-EXISTING SIMILAR MEDICAL CONDITION OR A PRIOR INJURY TO THE AFFECTED BODY AREA? IF SO, PLEASE EXPLAIN.

8. DID THE INJURY EXACERBATE PRE-EXISTING CONDITIONS? ☐ Yes ☐ No IF YES, HOW LONG WILL THE EXACERBATION LAST?

9. PLEASE IDENTIFY THE PERCENTAGE OF TREATMENT RELATED TO THIS CRIME.

10. ARE THE SERVICES RENDERED RELATED TO THE CRIME RELATED INJURIES AS DESCRIBED IN SECTION 5? ☐ Yes ☐No

11. IS THE VICTIM IN NEED OF MEDICATION DUE TO THE CRIME RELATED INJURIES? ☐ Yes ☐ No IF YES, LIST ON BACK

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| 12. DID INJURY REQUIRE HOSPITALIZATION? ☐ Yes ☐ No<br>IF YES, DATE OF ADMISSION (Mo, day, year)<br>DATE OF DISCHARGE | 13. IS ADDITIONAL HOSPITALIZATION REQUIRED?<br>☐ Yes ☐No |
| 14. CRIME RELATED OPERATIONS (If any, describe type) | 15. DATE OF OPERATIONS PERFORMED (Mo, day, year) |
| 16. WHAT IS THE FREQUENCY AND DURATION OF RECOMMENDED TREATMENT: | 17. WHAT PERMANENT EFFECTS, IF ANY, DO YOU ANTICIPATE? |
| 18. WHAT (Other) TYPE OF TREATMENT DID YOU PROVIDE? | |

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| 19. DATE OF FIRST EXAMINATION (Mo, day, year) | 20. DATES OF TREATMENT (Mo, day, year) | 21. DATE OF DISCHARGE FROM TREATMENT (Mo, day, year) |
| 22. DO YOU BELIEVE THE VICTIM WAS DISABLED DUE TO THE CRIME RELATED INJURIES?<br>☐ Yes ☐ No | 23. PERIOD OF DISABILITY (If termination date unknown – so indicate) (Mo, day, Year)<br>TOTAL DISABILITY: FROM TO<br>PARTIAL DISABILITY: FROM TO | 24. DATE VICTIM ABLE TO RESUME (Mo, day, year)<br>LIGHT WORK<br>REGULAR WORK |

25. IF VICTIM IS ABLE TO RESUME WORK, HAS HE/SHE BEEN ADVISED? ☐ Yes ☐ No If YES, FURNISH DATE ADVISED

26. IF VICTIM IS ABLE TO RESUME ONLY LIGHT WORK, INDICATE THE EXTENT OF HIS/HER PHYSICAL LIMITATIONS AND THE TYPE OF WORK HE/SHE COULD REASONABLY PERFORM WITH THESE LIMITATIONS.

27. IS MEDICAL AND/OR VOCATIONAL REHABILITATION INDICATED? ☐ Yes ☐ No

| LIST MEDICATIONS PRESCRIBED FOR CRIME RELATED INJURIES FROM BOX 11 | |
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THE OFFICE OF VICTIM SERVICES WILL REVIEW AND DETERMINE THE REASONABLENESS OF RELATED MEDICAL EXPENSES SUBMITTED TO THE OVS FOR PAYMENT. PLEASE KEEP IN MIND THAT THE OVS IS THE PAYER OF LAST RESORT. CONSEQUENTLY, ALL EXISTING INSURANCE WHICH THE CLAIMANT HAS MUST BE EXHAUSTED PRIOR TO SUBMISSION TO THE OVS.

| DATE OF SERVICE | PLACE OF SERVICE * | FULLY DESCRIBE PROCEDURES MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN | | CHARGES | | |
|---|---|---|---|---|---|---|
| | | **CPT PROCEDURE CODE** | *(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)* | | | |
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| 28. SIGNATURE OF PROVIDER (I certify that the statement on the reverse applies to this bill and is made a part hereof.) 29. DATE: | 30. HAS CLAIMANT PAID ANY PART OF THE BILL? ☐ Yes ☐ No | 31. TOTAL CHARGE | | 32. AMOUNT PAID | 33. BALANCE DUE |
|---|---|---|---|---|---|
| | 34. PROVIDER SOC. SEC. NO. | 35. PROVIDER'S NAME, ADDRESS, ZIP CODE AND TELEPHONE NUMBER | | | |
| 36. YOUR PATIENT'S ACCOUNT NO. | 37. PROVIDER TAX I.D. NO. | | | | |

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| 1 – INPATIENT HOSPITAL<br>2 – OUTPATIENT HOSPITAL<br>3 – DOCTOR'S OFFICE<br><br>O – OTHER LOCATIONS | 4 – PATIENT'S HOME<br>5 – DAY CARE FACILITY (PSY)<br>6 – NIGHT CARE FACILITY (PSY)<br><br>A – INDEPENDENT LABORATORY | 7 – NURSING HOME<br>8 – SKILLED NURSING FACILITY<br>9 - AMBULANCE<br><br>B -- OTHER MEDICAL/SURGICAL FACILITY |

**PLEASE NOTE: ALL BILLS FOR SURGICAL ROCEDURES MUST HAVE ACCOMPANYING OPERATIVE REPORTS.**

HAVE YOU MADE APPLICATION FOR SERVICES TO:

| | | | |
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| BLUE SHIELD | YES ☐ NO ☐ | MEDICAID | YES ☐ NO ☐ |
| WORKER'S COMPENSATION | YES ☐ NO ☐ | ANY INSURANCE COMPANY | YES ☐ NO ☐ |
| MEDICARE | YES ☐ NO ☐ | | |

IF "YES" TO ANY, PLEASE STATE THE FOLLOWING:

OTHER INSURANCE COMPANY

NAME AND ADDRESS _____ NAME AND ADDRESS _____

POLICY NUMBER _____ POLICY NUMBER _____

AMOUNT REC'D _____ AMOUNT REC'D _____