



CRIME VICTIM'S INVOICE

1050 17th Street NW, Suite 1000,
 Washington DC 20036
 202-292-9322(p) 888-551-5262 (f)

Section 1: Victim's Information – Name of person injured or deceased as a result of a violent crime.				Section 2: Crime Information: <input type="checkbox"/> Arson <input type="checkbox"/> Domestic Abuse <input type="checkbox"/> Homicide <input type="checkbox"/> Assault <input type="checkbox"/> Kidnapping <input type="checkbox"/> Car Jacking <input type="checkbox"/> Sexual Assault <input type="checkbox"/> Robbery <input type="checkbox"/> Drunk Driving <input type="checkbox"/> Cruelty to Children <input type="checkbox"/> Stalking <input type="checkbox"/> Burglary <input type="checkbox"/> Threats <input type="checkbox"/> Other	
Victim's Name (Last, First, & MI):					
Is the Victim Deceased? <input type="checkbox"/> No <input type="checkbox"/> Yes	Date of Birth (Month/Day/Year): / /	Gender : <input type="checkbox"/> Female <input type="checkbox"/> Male			
Street Address (Including Apt #):		City:	State:		Zip Code:
Home Telephone Number: ()	Work Telephone Number: ()	Cell Phone Number: ()			
E-mail Address:	Contact name (Another person we can contact to reach you):	Contact Phone Number: ()			
What is the preferred contact method during the day? <input type="checkbox"/> Home phone <input type="checkbox"/> Cell phone <input type="checkbox"/> Work phone <input type="checkbox"/> Any phone <input type="checkbox"/> E-mail <input type="checkbox"/> N/A					

Section 3: Claimant's Information – Name of person filling on behalf of deceased victim, minor, or an incapacitated adult.				Section 4: Dates of Treatment: _____ _____ _____ _____ _____ _____ _____ _____	Amount billed: _____ _____ _____ _____ _____ _____ _____	
Claimant's Name (Last, First, & MI):						
Home Telephone Number: ()	Date of Birth (Month/Day/Year): / /	Gender : <input type="checkbox"/> Female <input type="checkbox"/> Male				
Street Address (Including Apt #):		City:	State:			Zip Code:
E-mail Address:	Work Telephone Number: ()	Cell Phone Number: ()				
Your relationship to victim:	Emergency contact:	Contact Phone Number: ()				

Section 5: Primary Concerns:

Name or Provider: _____

Signature: _____

NPI: _____

Date: _____

EIN: _____