



NEW MEXICO CRIME VICTIMS REPARATION COMMISSION
6200 UPTOWN BLVD NE SUITE 210 ALBUQUERQUE, NM 87110
Phone: (505) 841-9432 • Toll-Free: (800) 306-6262 • Fax: (505) 841-9437
Website: www.cvrc.state.nm.us • E-mail: cvrc.office@cvrc.nm.gov

Mental Health Treatment Plan

An application for crime victim compensation has been submitted to the New Mexico Crime Victims Reparation Commission (CVRC) under the Crime Victims Reparation Act [NMSA 31-22-1]. The Act requires verification of information to be reviewed for eligibility.

The responsibility for any charges for your services remains with the patient. CVRC assumes no responsibility until an application has been approved for eligibility. The Commission is neither an insurance company nor a program of entitlement. All attempts to have insurance, Medicaid, Medicare, or indigent funds pay for the treatment must be made prior to our consideration. Per federal law, our agency is the payer of last resort.

In all cases of mental health care, the Commission shall approve for payment no more than 30 total visits per application submitted unless prior approval for additional treatment has been granted. This prior approval must be requested by the provider and must clearly document the need.

Any evaluation and counseling shall be performed by a licensed provider in accordance with their State. Those providers awaiting licensure approval must be under the direct supervision of a licensed professional. Treatment is to be directed towards coping with crime specific issues. Counseling must be directly related to the incident in order to be eligible. Telehealth services will be considered.

At any time during treatment, the Commission may require a follow-up report or prognosis notes from the provider detailing the results of the treatment and setting forth the need for continuing treatment. The provider shall provide the Commission with a detailed report explaining why continuing treatment is necessary. In-patient hospitalization may only be considered in life-threatening situations when the treatment has been recommended, in writing, by the victim's physician or mental health provider.

The Commission will not consider payment for the following: missed appointments, report writing, court appearances, therapist travel time/costs, interest, telephone calls to the Commission office, and sessions which include the offender. If the victim has health insurance that provides payment for mental health therapy, but requires a co-pay from the victim, the Commission is willing to accept a copy of the treatment plan that you provide to the victim's insurance company in lieu of our enclosed form. Please submit additional bills and requested documentation on a timely basis.

When the victim is a minor, a therapist shall not receive reparation if providing dual treatment to the minor victim and their offender.

Please complete the attached treatment plan, as this documentation is required for dates of service to be considered for payment.



NEW MEXICO CRIME VICTIMS REPARATION COMMISSION
 6200 UPTOWN BLVD NE SUITE 210 ALBUQUERQUE, NM 87110
 Phone: (505) 841-9432 • Toll-Free: (800) 306-6262 • Fax: (505)841-9437
 Website: www.cvrc.state.nm.us • E-mail: cvrc.office@cvrc.nm.gov

Client Information

Client Name	Client Date of Birth
Claimant Name	CVRC Claim No. (if applicable)

Financial Information (Please submit an itemized invoice)

Client's health insurance carrier

Health insurance policy number	Is the client uninsured? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is insurance being billed? Yes <input type="checkbox"/> No <input type="checkbox"/> (if no, explain why)	

Treatment Information (Attach additional pages if needed)

Detailed patient evaluation describing the effect of the victimization:

Presenting complaints:

Pre-existing conditions:

Treatment goal/plan:

Method for accomplishing treatment goals:

Medication prescribed and reason:

Estimated length of treatment:	Is treatment related to the victimization? <input type="checkbox"/> Yes <input type="checkbox"/> No
--------------------------------	---

Provider Information

Provider Name	License Number		
Mailing Address	City	State	Zip Code
Phone Number	E-mail Address		
Provider Signature	Date		