South Carolina Attorney General's Office
South Carolina Crime Victim Services Division
Department of Crime Victim Compensation (DCVC)

DCVC Mental Health Counselor's Report

Victim's Legal Name: _____

Today's Date: _____ Claimant (If different person)_____

Last 5 digits of SSN: _____ - _____ Crime Date: _____

To the Provider: This form is used for consideration with the initial 20 mental health sessions. To request approval/pre-authorization for payment of additional sessions, you must submit the "Additional Counseling Sessions Request Form."

You must submit this form to request approval/pre-authorization for payment of counseling sessions. The treatment must be directly related to the crime on which the claim is based. You must include a goal-directed treatment plan and a summary of your assessment toward meeting those goals.
Approval/pre-authorization is contingent upon the rationale behind the need and the details provided.

Are the trauma and the treatment a direct result of this crime? YES ☐ NO ☐
Presenting Issue: _____
_____
Description of psychological trauma as related to victimization: _____
_____
_____
Type of evidence based treatment model used:_____
_____

Payer of Last Resort Status
The Department of Crime Victim Compensation is the payer of last resort. If the victim has insurance including Medicaid or Medicare, and the victim elects not to use his/her insurance for treatment, DCVC will not cover the cost. It is the provider's responsibility to ensure that other avenues of payments are explored and used.

The following question must be answered: Does this victim have health insurance coverage? YES _____ NO _____
If the victim has health insurance, DCVC will pay after the insurance pays. Please provide the following information along with a copy of the Explanation of Benefit (EOB) for each Date of Service (DOS):

Heath Insurance Carrier: _____ Policy No. _____

_____	_____	_____
Authorized signature of Treating Therapist/Counselor	Printed name of Payee	Phone number/extension
_____	_____	_____
License Type & Number	Mailing Address	City/State/Zip
_____	_____	_____/_____/_____
Supervisor's Signature	License Type & Number	Date