

Crime Victims' Compensation Portal Tutorial for Advocates

Crime Victim and Survivor Services Division

The purpose of this document is to provide advocates with guidance on using the Crime Victims' Compensation Portal when assisting victims.

Updated 11/12/23



Oregon Department of Justice
Crime Victim and Survivor Services Division
Every victim, every crime, every right, every time.



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Portal Use

You may have limited access to the Crime Victims' Compensation (CVC) portal to assist victims with applying for and managing their claim. Additional functions of the portal include:

- Uploading documentation
- Viewing claim status and payment information
- Searching for claims using a claim number
- Identifying and e-mailing the claim examiner

For CVC to process an application, it must include an electronic or uploaded signature of the victim/applicant. The victim or applicant can digitally sign the application before submitting it to CVC.

Portal Access

You must register for portal access at:

<https://justice.oregon.gov/victims/compensation/Account/Login>.

1. Click on "Register."
2. Select "Advocate" as your role.
3. Enter your information and create a password. Passwords must be a minimum of 14 characters and at least one lowercase and one uppercase letters.
4. Click "Register."
5. Wait for a message stating your registration was approved, then confirm your email address.

Things to Know

- Once you have submitted your registration, CVC will review and approve your access. This takes between one and three business days.
- Once CVC approves your access, we ask you to confirm your email address.
- You must use your work email address to register.
- You will have access to claims in your county. If you serve multiple counties, contact CVC to expand your access.
- If you submit an application for a victim, they can contact CVC at CVSSDPortal@doj.state.or.us and ask to be linked to their claim.
 - *The victim or applicant must register for the portal first.



Submitting an Application

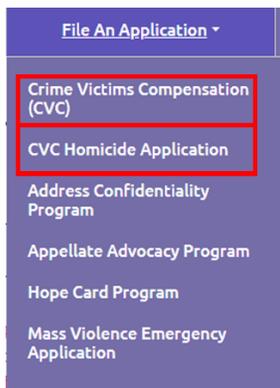
You may assist victims or applicants in filling out an application. The victim or applicant must sign the application before you submit it. They can digitally sign the application or upload a signature page once CVC has imported their application.

Application Options

1. Use the **Crime Victims' Compensation Application** for all compensable crimes except homicides or witness to homicides.
2. Use the **Homicide Application** for a deceased victim or a person who witnessed a homicide.

Application Access

1. Log in to the portal - <https://justice.oregon.gov/victims/compensation/Account/Login>.



2. Select "File an Application."
3. Select "Crime Victims' Compensation" or "Homicide Application."

Crime Victim Compensation Application: Required Information

We have highlighted required fields in yellow.



Who referred you to our program?

APPLICATION FORM

Please complete the highlighted fields. These fields are required before you can submit your application. Read the instructions in that section to see if the information is required for your situation.

Who referred you to our program?

Police Victim Services/Advocate Medical Provider
 Tribal Advocate Child Advocacy Center Other:

I am filing out this application because I am (check one):

The victim of a crime Another reason (explain):
 The parent/guardian of a crime victim under 18 years of age

You should select “Victims Services/Advocate” if you are an advocate with the DA’s office or a non-profit organization.

Victim Information

Victim Information (Person who is injured.)

First Name:		Middle Name:	Last Name:	
Date of Birth:	Pronoun	Preferred Language: English	Phone:	
Mailing Address:	Apt #:	City:	State: Oregon	Zip:
May we contact you by email? Please select		If yes, please provide your email address:		

You must always complete the Victim Information section.

Victim Information

- If the victim is homeless:** Add “homeless” to the mailing address or list the address of a friend or family member whose address is okay to use.
- If a child victim is in DHS custody:** Add the address of the DHS office where the child’s caseworker works.
- E-Mail:** If the victim or applicant prefers to have CVC contact them by e-mail, please provide their e-mail address.

Applicant Information (Legal Guardian)

Applicant Information (Parent or guardian of injured victim. If you are applying for someone else, information highlighted is required.)

First Name:		Middle Name:	Last Name:	
Mailing Address:	Apt #:	City:	State: Oregon	Zip:
Phone:		Preferred Language: Select a Language		
Date of Birth:	Pronoun	Your relationship to the victim Select a Relationship		
May we contact you by email? Please select		If yes, please provide your email address:		

CVC requires you to complete this section if the victim is under the age of 14.



Optional Contact

Optional Contact Person (Person we can talk to about your claim)		
First Name:	Last Name:	Preferred Language:
Contact person's phone:	Contact Person's Email:	Contact person's relationship to the victim: ▼

Examples for optional contacts include a family member (e.g., another parent) or close friend.

Advocate Information

Advocate Information (The victim services person or advocate assisting you with this application, if applicable)			
Advocate name: First Name	Last Name	Advocate e-mail:	Advocate phone#: County: Marion ▼

The contact information you provided in your portal profile should auto-populate in this section.

Insurance Information

Insurance Information	
What insurance did the victim have at the time of the crime? Please check ALL that apply.	
<input type="checkbox"/> Private Health Insurance	<input type="checkbox"/> Medicare <input type="checkbox"/> Dental
<input type="checkbox"/> Oregon Health Plan	<input type="checkbox"/> Workers' Compensation <input type="checkbox"/> None
If the victim had private health insurance, insurance company information is required. List all insurance information below and use additional pages if necessary.	
Insurance Company Name:	

Check the boxes for any of the insurance coverage the victim has including Oregon Health Plan, private health insurance (e.g., Blue Cross, MODA, Cigna, Keizer, etc.), and/or dental.

*If the victim has private insurance, CVC requires you list the name of the insurance company.

Provider Information

Provider Information (If victim saw a provider for crime-related injuries, CVC will request medical records. If CVC approves your application, you will have the opportunity to submit bills/statements for crime-related expenses.)			
Did the victim have any medical treatment because of the crime? If yes, information for the initial crime-related visit (hospital, urgent care, or medical office) is required.:			No ▼
Provider Name and Facility Name:	Date of Service:	Address or Email:	
City:	State: Select a State ▼	Zip:	Phone Number:

If the victim saw a provider for crime-related injuries, fill out this section.



Crime Information

Crime Information (Required for all claims)				
Type of Crime Select Type of Crime	Did the crime involve a vehicle?: Please select	Do you have auto insurance? No		
If yes, auto insurance name:		Claim #		
Please indicate which of the following apply:				
<input type="checkbox"/> Reported to law enforcement		<input type="checkbox"/> Obtained protective order		<input type="checkbox"/> None
<input type="checkbox"/> Reported to a medical provider		<input type="checkbox"/> SANE or SKIT exam		
Provider Name and Facility Name:		Provider Address or Email:		Provider Phone Number:
Alleged Suspect (if unknown add N/A below): First Name				Date of Birth:
Last Name				
Additional Suspect (if applicable): First Name				Date of Birth:
Last Name				
Date of Crime:	Date Reported:	Report Number:		
Name of Police Department reported to: Select Police Department		Name of Officer:		
Location of Crime - Address:		City:	State: Oregon	Zip: Select County

While it is helpful to have as much information as possible about the crime, CVC only requires the highlighted fields.

Crime Information

- Type of Crime:** Select the type of crime that describes the incident.
- Did the crime involve a vehicle?** Mark this question as “yes” if a vehicle was involved or if the victim was in a vehicle when the crime occurred.
- Please indicate which of the following apply:** Select all options that pertain to reporting the crime. If the victim reported the crime to a medical provider or completed a SANE/SKIT exam, then CVC requires you to list the provider information. If the victim reported the crime to law enforcement, then CVC requires the name of the police department. If the victim selects “none” and the crime is a compensable crime, CVC can offer a counseling only benefit.
- Alleged Suspect:** If the suspect is unknown, type “unknown” in the first and last name fields.
- Date of Crime:** CVC requires you to answer this field.
- Name of Police Department:** Select the law enforcement agency that received a report about this incident.
 - If the victim or applicant did not report the crime, mark “unreported” and provide an explanation in the next box.
 - If someone reported the crime to the Oregon Department of Human Services, select “DHS.”
- Location of Crime:** Be as specific as possible. This can be an address, intersection, or the name of a business.



Loss of Earnings

Loss of Earnings (if the victim lost wages because of the crime)		
Did the victim lose earnings due to the crime?	Please Select	
Workdays: <input type="checkbox"/> Monday <input type="checkbox"/> Wednesday <input type="checkbox"/> Friday <input type="checkbox"/> Sunday <input type="checkbox"/> Tuesday <input type="checkbox"/> Thursday <input type="checkbox"/> Saturday <input type="checkbox"/> Varies	Average hours per week:	Hourly Wage: \$
Name of Victim's Employer:	Phone:	Address or Email:
Has the victim returned to work? Please select	Date returned to work:	Did the victim miss more than two weeks of work? Please Select
Name of Victim's Doctor/Mental Health Provider & Facility:	Phone:	Address or Email:

Victims who were employed at the time of the crime and lost earnings as a result may request loss of earnings. Employment will be verified. If victim missed more than 2 weeks of work, CVC requires a work release.

Additional Information

Additional Information (if you wish to add additional information, please remember this application may be subject to disclosure under public record law.)

Let the applicant know that because of public record law, anything they add to this section may be subject to disclosure.

Counseling

Counseling (if the victim is currently or will be seeking mental health services please list the counselors information below)				
Therapist's Name:		Address or email:		
City:	State: Select a State	Zip:	Phone Number:	
Additional Counseling (Such as counseling for a child witness to domestic violence, or a family member of a child victim of sexual or physical abuse)				
Is there anyone besides the victim who is or will be receiving counseling as a result of the crime?				No
Name of Family Member:		Date of Birth:	Relationship to Victim:	Insurance Carrier:
First Name	Last Name			
First Name	Last Name			
First Name	Last Name			

If the victim has a counselor, they can list the information above, and CVC will send a counseling packet to the provider.

For each family member listed, include their name, date of birth, relationship to the victim, and insurance carrier.

This benefit is for immediate family members of victims of child physical or sexual abuse.

Children who have witnessed domestic violence and individuals who were the first to discover the corpse of a friend or acquaintance may also be eligible for this benefit.



For more details on how many sessions CVC authorized please contact the claim specialist.

Civil Attorney Information

Civil Attorney Information			
Have you retained an attorney for a civil lawsuit related to this crime?			No
Attorney Name:		Phone:	Email Address:
First Name	Last Name		
Address:	City:	State: Select a State	Zip:

If the victim hired a civil attorney in relation to this incident, select “yes” from the drop-down menu. If you select “yes,” CVC requires you to complete the remainder of the fields in this section.

Digital signature section and explanation of electronic signature

Signature – By signing this application, I declare under penalties of unsworn falsification that the information in this application is true and accurate. I authorize the Crime Victims’ Compensation program of the Oregon Department of Justice to verify any information on this application.

By checking this box and typing my name below I am electronically signing my application. I understand that my electronic signature has the same legal effect and can be enforced in the same way as my handwritten signature.

Signature of Victim/Applicant: _____ Date: _____

Due to providers requiring “written” signatures CVC asks that you sign with your mouse or finger (if touchscreen) in the box below.

Clear Signature

Signature of 14-17 year old: _____ Date: _____

A typed signature is required. The written digital signature is not required; however, some providers will require an actual signature to release information. If a victim or applicant would like to create a written digital signature, they can use a mouse or a touch screen device to do so.

Submit

Submit

Once all the required fields (highlighted yellow) are complete, click “submit.” If you did not provide all the required information, or if the signature does not match the name on the application, you must correct these items before submitting the application.

Missing Information

If you left a required field blank, the portal automatically redirects you to the incomplete section and provides additional instructions in red font.



Who referred you to our program?

You must check at least one who referred you checkbox.

<input type="checkbox"/> Police	<input type="checkbox"/> Victim Services/Advocate	<input type="checkbox"/> Medical Provider
<input type="checkbox"/> Tribal Advocate	<input type="checkbox"/> Child Advocacy Center	<input type="checkbox"/> Other: <input type="text"/>

I am filing out this application because I am (check one):

<input type="checkbox"/> The victim of a crime	<input type="checkbox"/> Another reason (explain): <input type="text"/>
<input type="checkbox"/> The parent/guardian of a crime victim under 18 years of age	

Signature Error

If you receive the signature error, check that the name in the Victim Information section (or Applicant Section, if used) matches exactly.

- Check for and remove extra spaces in the name fields. This is the most common cause of a signature error.
- If you enter a middle name, make sure to include it in the signature as well.

By checking this box and typing my name below I am electronically signing my application. I understand that my electronic signature has the same legal effect and can be enforced in the same way as my handwritten signature.

Signature of Victim/Applicant: Date:

The signature must match either the victim or the applicant.

Application Submitted

Tutorial for Advocates	How Do I	Search Claims	Hope Card Survey	File An Application -	Christ
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Your Online Web Claim Submission has been submitted. Your Online Submission Id is **87980**.

Please allow 2 - 3 days to access claim.

Documents cannot be uploaded when you submit an application. An email will be generated to the person who applied letting them know when documents can be uploaded.

If you have any questions email: cvssd@doj.state.or.us

[Go back to Search](#)

- Immediately after submitting the application, you will receive confirmation and the submission ID.
- As an advocate, you have access to claims you submitted under the Claims Submissions section.
- Once they receive the application and import it into the system, CVC sends an email that includes the assigned claim number.



Homicide Application: Required Information

Type of Crime

Homicide Application Form	
Please complete the highlighted fields. These fields are required before you can submit your application.	
Type of Crime	Select Type of Crime

This application also includes witness to homicide.

Victim Information

Victim Information (Person who is deceased. Date of death is required)		
First Name:	Middle Name:	Last Name:
Date of Birth:	Date of Death:	

You must always complete the Victim Information section.

Applicant Information

Applicant Information (Family member of deceased victim, the person who witnessed the homicide, or the person who is financially responsible for the funeral.)				
First Name:	Middle Name:	Last Name:		
Mailing Address:	Apt #:	City:	State: Oregon	Zip:
Phone:	Preferred Language: Select a Language	Date of Birth:	Pronoun	Your relationship to the victim Select a Relationship
May we contact you by email? Please select	If yes, please provide your email address:			

This section is required for homicide claims. A family member of the deceased victim, a person who is financially responsible for the funeral or the person who witnessed the homicide.

Crime Information

Crime Information			
Did the crime involve a vehicle?: Please select	Do you have auto insurance? No	If yes, auto insurance name:	Claim #
Alleged Suspect (if unknown add N/A below):		Date of Birth:	
First Name	Last Name		
Additional Suspect (if applicable):		Date of Birth:	
First Name	Last Name		
Date of Crime:	Report Number:	Name of Police Department reported to: Select Police Department	
Location of Crime - Address:	City:	State: Select a State	County: Select County

Complete the highlighted fields. Depending on the applicant's response to certain fields, other fields might become required.

Crime Information

- 1. Did the crime involve a vehicle?** Mark this question as "yes" if a vehicle was involved or if the victim was in a vehicle when the crime occurred.



2. **Crime Date (required):** If you do not know the exact date, enter your best estimate.
3. **Alleged Suspect:** If the suspect is unknown, type “unknown” for first and last name.
4. **Name of Police Department:** Select the law enforcement agency that received a report about this incident.
 - a. If the victim or applicant did not report the crime, mark “unreported” and provide an explanation in the next box.
5. **Location of Crime:** Be as specific as possible. This can be an address, intersection, or the name of a business.

Additional Information

Additional Information

Let the applicant know that because of public record law, anything they add to this section may be subject to disclosure.

Optional Contact

Optional Contact Person <small>(Person we can talk to about your claim)</small>		
First Name:	Last Name:	Preferred Language:
Contact person's phone:	Contact Person's Email:	Contact person's relationship to the victim: ▼

The optional contact person is someone the victim or applicant gives CVC permission to discuss their claim. CVCP is unable to talk to any person who the victim did not list in this section. If preferred, the optional contact person may act as the primary point of contact for CVCP.

Examples for optional contacts include a family member or close friend.

Advocate Information

Advocate Information <small>(The victim services person or advocate assisting you with this application, if applicable)</small>			
Advocate name:	Advocate e-mail:	Advocate phone#:	County:
First Name Last Name			Marion ▼

The contact information you provided in your portal profile should auto-populate in this section.

Medical Treatment Information



Medical Treatment Information

Was the victim transported to the hospital if yes, name of hospital:	Please Select
Hospital name:	
Did the victim have medical insurance? (mark any that apply)	
<input type="checkbox"/> Private Health Insurance <input type="checkbox"/> Oregon Health Plan <input type="checkbox"/> Medicare <input type="checkbox"/> None	Name of private insurance:

If the victim was transported to the hospital, this section is required.

Civil Attorney

Civil Attorney			
Have you retained an attorney?			No
Attorney Name:		Phone:	Email Address:
First Name	Last Name		
Address:	City:	State: Select a State	Zip:

If a civil attorney in relation to this incident has been obtained, select “yes” from the drop-down menu. If you select “yes,” CVC requires you to complete the remainder of the fields in this section.

Loss of Support

Loss of support (Dependents of the deceased victim may be eligible for loss of support. Guardians of the dependents must apply for these benefits)			
Was the victim employed on the date of the crime?		Please Select	
Name of Victim's Employer:		Address and/or Email:	
		Phone:	
At the time of death, was the victim financially supporting any dependents?			No
Name of Dependent:		Date of Birth:	Address:
First Name	Last Name		Relationship to Victim:
First Name	Last Name		

The victim must have been employed at the time of the incident and supporting dependents. CVC will verify employment.

Funeral Information

Funeral Information (Please list all out-of-pocket and unpaid funeral expenses)					
Provider of funeral services:	Address:	City:	State:	Zip:	Phone:
			Select a State		
			Select a State		



Additional Counseling

Additional Counseling (Such as counseling for surviving family members of homicide victim)				
Are there additional family members seeking counseling as a result of the victims death? .				No
Name of Family Member:		Date of Birth:	Relationship to Victim:	Insurance Carrier:
First Name	Last Name			
First Name	Last Name			
First Name	Last Name			

For each family member listed, include their name, date of birth, relationship to the victim, and insurance carrier.

This benefit is for immediate family members of the deceased victim.

Digital Signature

Signature – By signing this application, I declare under penalties of unsworn falsification that the information in this application is true and accurate. I authorize the Crime Victims' Compensation program of the Oregon Department of Justice to verify any information on this application.

By checking this box and typing my name below I am electronically signing my application. I understand that my electronic signature has the same legal effect and can be enforced in the same way as my handwritten signature.

Signature of Applicant	Date:

Due to providers requiring "written" signatures CVC asks that you sign with your mouse or finger (if touchscreen) in the box below.

Clear Signature

A typed signature is required. The written digital signature is not required; however, some providers will require an actual signature to release information. If an applicant would like to create a written digital signature, they can use a mouse or a touch screen device to do so.

Submit

Submit

- Once all the required fields (highlighted in yellow) are complete, click "submit."
- If you miss a required field, the portal will redirect you to the incomplete section.
- Signature Error: If you receive the signature error, check that the name shown in the applicant section matches the signature exactly.
 - Check for and remove any extra spaces in the name fields. This is the most common cause of a signature error.
 - If you enter a middle name, make sure to include it in the signature as well.



By checking this box and typing my name below I am electronically signing my application. I understand that my electronic signature has the same legal effect and can be enforced in the same way as my handwritten signature.

Signature of Victim/Applicant: Date:

The signature must match either the victim or the applicant.

Application Submitted

Tutorial for Advocates | How Do I | Search Claims | Hope Card Survey | File An Application - | Christ

Your Online Web Claim Submission has been submitted. Your Online Submission Id is **87980**

Please allow 2 - 3 days to access claim.

Documents cannot be uploaded when you submit an application. An email will be generated to the person who applied letting them know when documents can be uploaded.

If you have any questions email: cvssd@doj.state.or.us

[Go back to Search](#)

- Immediately after submitting the application, you will receive confirmation and the submission ID.
- As the advocate who submitted the application you will have access to it under the Claims Submissions section.

Exploring the Portal

Claim Search

There are two main ways to locate a claim.

1. If you helped the victim fill out an application through your account on the portal, the claim will appear under Claims Submissions. Use the filter to search if you have a lot of claims in your view.

Claim Submissions						
Note: If you'd like access to claims filed online prior to the portal, please email cvssdportal@doj.state.or.us .						
Filter: <input type="text"/>						Show 10 ▾
Edit	Claim Number	Online Submission Id	Submission Date	Victim	Application Status	
		52262	09/03/2019	cecilia test	Submitted	

Claim Submission – Field Explanation

1. **Edit:** The edit icon is not available under the advocate role since you are not able to save changes to applications.
2. **Claim Number:** The number CVC assigns to a victim's application.
3. **Online Submission Id:** CVC assigns this ID at the time they receive the application.
4. **Victim:** The name of victim/survivor.
5. **Application Status:**
 - a. **“Submitted”:** CVC has received the application but has not yet reviewed it.
 - b. **“Duplicate”:** CVC received an application previously. Contact CVC for the claim number.
 - c. **“Received”:** CVC received and imported the application into their system.



- If you did not help the victim apply through your portal account, you can search for it by the claim number. Do this by entering the numerical part of the claim number. If you do not have the claim number, e-mail CVSSD to request it at cvssd@doj.state.or.us.

Search Claims

Search: CV:

*NOTE: To make searching simple please enter only the number in a CV number (example 01234-01)

The search results will populate below.

	Claim Number	Victim	Claim Determination Status	Date Received	Claim Expiration Date	Assigned Examiner	Assigned Specialist	Status	
Select Claim	CV 05029-07	Doe, Jane Mary	Accepted - Reconsideration, denial overturned	07/02/2019	04/12/2028	Christy Simon	Not Assigned	z-Test Claim	

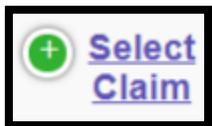
Search Field Explanation

- Claim Number:** The number CVC assigns to a victim’s application.
- Victim:** The name of victim/survivor.
- Claim Determination Status:** The determination status of the claim.
- Date Received:** The date when CVC received the application.
- Claim Expiration Date:** The date when the claim will expire.
- Assigned Examiner:** The person who determines eligibility.
- Status:** Status of the CVC claim (different from the determination status).
 - “Predetermined”:** CVC is reviewing the claim.
 - “Inactive”:** CVC accepted the claim, but moved it to an inactive status due to lack of activity (e.g., no bills)
 - “Open-Accepted”:** CVC is actively processing bills or requesting information.
 - “Counseling Only”:** Accepted for a counseling only benefit.
 - “Hold No Signature:** CVC has not received a signed release; a request was sent to the victim or applicant.
 - “Suspended No Signature”:** CVC did not receive the signature, so the claim was placed in a suspended status until the release is received.

Claim Information

Claim Detail

To see claim information, click on “Select Claim.”



This section shows information about the claim including the date of the crime, the victim’s insurance information, and the determination status.



Claim Detail

Victim: Doe, Jane Mary
 Claim Number: CV 05029-07
 Date Received: 07/02/2019
 Status: z-Test Claim
 Claim Expiration Date: 04/12/2028
 Date Of Crime: 12/12/1996
 Referred By: Victim Assist Program
 Examiner Assigned: Christy Simon
 Specialist Assigned: Not Assigned
 Reported To: Albany Police Department
 Date Reported: 02/18/2021
 Crime County: Multnomah
 Determination Status: Accepted - Reconsideration, denial overturned
 Determination Date: 04/12/2023

Insurance Information Section: You can see the name of the current insurance company, the effective date, and the policy number (or OHP ID).

Insurance

Filter: Show 10

Organization Name	Insured Name	Type	Effective Date	Policy Number
OHP	testing app	Current Health Insurance	2/1/2019 12:00:00 AM	XTY890

From this page you can tab to “Payments” and “Forms.” You can also return to the main page by clicking on “Claims Search.”

Payment

By selecting the “Payment” tab, you will see payments that are pending or authorized under the claim.

Replace below screen shot with the one from the provider tutorial.

Payments

Filter: Display 25

	Pay To	Transaction Type	Provider Name	Amount Paid
Detail	Jane Mary Doe	Loss of Earnings		\$360.00
Detail	Bugs Bunny	Ambulance		\$0.00
Detail	Bugs Bunny	Counseling Benefit		\$0.00
Detail	Tammy Doe	Loss of Earnings		\$1,500.00
Detail	Bruce Wayne	Counseling		\$40.00

Payment – Field Explanation

- Detail:** Additional information for that specific payment.
- Pay To:** The person or provider to whom CVC paid.
- Transaction Type:** The type of service the victim received.
- Provider Name:** The provider who provided the service the victim.
- Amount :** The amount CVC has paid or is reviewing in the claim.



Payment Detail

Click on “detail” of the payment for more information (pending payment – update below screen shot with #2 in provider tutorial).

Payment Detail	
Pay To:	Western Psychological & Counseling - Corporate
Date Service Started:	02/15/2017
Date Service Ended:	03/09/2017
Provider Name:	Western Psychological & Counseling - Corporate Counseling
Transaction Type:	Counseling
Account Number:	
Date Bill Received:	
Amount Billed:	\$700.00
Amount Allowed:	
Paid By Prior:	(\$0.00)
Fee Schedule:	(\$275.00)
Other Deductions:	(\$0.00)
Amount Of Payment:	\$425.00
Authorized By:	Cecilia Lucero
Date Authored By:	02/13/2018
Check Comments:	Dates of service 2/15/17 (Intake), 2/22/17, 3/2/17, & 3/9/17. 12 Counseling hours.
Check Request Verbiage:	Fee Schedule Reduction LCSW, LPC, LMFT

[Close](#)

Authorized payment:

Add screen shot #3 from provider tutorial

Payment Detail – Field Explanation

1. **Provider:** The name of the service provider.
2. **Transaction Type:** Type of medical or counseling services that were received.
3. **Dates of service:** Date treatment was provided for all dates included in this payment.
4. **Bill Received:** The date CVC received the bill.
5. **Amount Billed:** The amount the provider charged, which may include several dates of service.
6. **Insurance Pay:** the amount insurance paid.
7. **Insurance Adj:** The amount shows the victim's insurance adjustment.
8. **Fee Schedule:** The amount a provider writes-off that they must take if they accept payment from CVCP.
9. **Other Deductions:** May include out-of-pocket payments or restitution paid to the provider or victim.
10. **Payment:** the amount CVC is reviewing or has authorized.



11. **Payment Pending:** the payment is being reviewed, and additional information may be requested from the provider.
12. **Authorized by:** The person who authorized the payment at CVC.
13. **Date Authorized:** The date CVC authorized the payment and sent to fiscal for payment processing.
14. **Explanation:** This could include information that CVSSD needs to relay to the provider. If a payment is still pending there will be a notice to the provider of any information that has been requested before further processing can occur.
15. **Comments:** Additional comments, which may note specific dates of service etc.
16. **Check Comments:** May include specific dates of services, counseling hours remaining, etc.

Forms

CVC will be adding more forms to the portal in the future. The “Getting Started with Crime Victims” is the initial letter we send to participants.

CV 05029-07

Claim Detail Payments Forms Claims Search

- Getting Started with Crime Victims-PDF (English)
- Getting Started with Crime Victims-PDF (Spanish)
- Authorize to Release (English)
- Authorize to Release (Spanish)
- Employment Verification (PDF)

Document Upload

You can upload the documents listed below through the portal. Please upload any statements or bills you receive from the victim.

Add Claim Document X

Category:

Select File Category ▼

Document File:

Choose File No file chosen

Submit Document

Documents associated with Claim

You can find this upload icon throughout the portal.



1. Select the upload icon for the appropriate claim.
2. Select Category – choose the type of document you are uploading.
3. Click on “Choose File” to browse your computer for the document.
4. Click on “Submit Document”

Contacting Us

If you have questions regarding a specific claim, contact us through the portal.

You can find the message icon throughout the portal.



Get Assistance on Claim ×

If you need assistance with Claim Number **CV 05029-07**, please submit an email request.

Select Question Type ▼

[Request Assistance](#)



Get Assistance on Claim X

Select Question Type ▼

- Select Question Type
- Determination
- Loss of Earning
- Other
- Payment Status (Bill)
- Restitution

Request Assistance

1. Select the message icon for the appropriate claim.
2. Select the type of question from the dropdown menu. This helps our system identify the best way to route your message.
3. Enter your message and then click “Request Assistance.”
4. Please allow one to three business days for a staff member to respond.

Billing Crime Victims’ Compensation

Crime Victims’ Compensation (CVC) assists victims with an accepted claim in paying for crime-related medical and counseling treatment. We’ve included this information to assist you in answering questions you may receive from victims. If you and/or the victim/applicant, have questions after reviewing the information below, please feel free to contact the assigned examiner through the CVC Portal. If you have questions about CVC that is not related to a claim, email advocateinquiries@doj.state.or.us.

Insurance

The victim will need to provide all necessary medical and auto (if appropriate) information to each provider. If the victim has insurance (including OHP), the provider must bill the insurance as primary. The provider must submit the explanation of benefits (EOB) to CVC. Providers must bill insurance in a timely fashion as CVC can only pay patient responsibility. If the primary insurance denies for untimely billing and there is no patient responsibility, CVC may deny payment as well.

Fee Schedule/Write-Off

If the patient does not have insurance, CVC will apply a Workers’ Compensation Fee Schedule. By law, the provider cannot bill the patient for the fee schedule (write-off).

Sending Victims to Collections

The victim will need to contact their providers to let them know that they have a CVC claim. If a provider has sent the victim to collections for any crime related medical bills, please notify CVC.



Counseling

- CVC does not require chart notes for counseling sessions unless requested.
- CVA requires a treatment plan after 30 sessions for a full CVC claim approval and 15 sessions if CVC accepts the claim for counseling only.
- CVC pays claims for licensed therapists only.
- CVC reimburses therapy using the CVC fee schedule
- Contact CVC with the name and address of the therapist so that CVC can send the provider a packet authorizing sessions.

Vision

- CVC will reimburse the provider for the exam and office visit using the workers comp fee schedule.
- The victim will need to pay for glasses and then CVC will reimburse them for their out-of-pocket expense. CVC cannot pre-pay for services.

Dental

- Dental work must be pre-authorized. The provider will need to submit a treatment plan and chart notes.
- CVC will reimburse the provider using the dental fee schedule when there is not dental insurance coverage.

Alternative Therapy (massage, acupuncture, chiropractic).

We require treatment notes for each date of service. If services are more than 6-months after the crime occurred, we may require additional verification.

For additional information, please refer to the CVC website for advocates:

<https://www.doj.state.or.us/crime-victims/crime-victim-compensation/for-advocates> or email advocateinquiries@doj.state.or.us.