Mental Health Counselor's Report

Rev. 08/14

State Office of Victim Assistance 1205 Pendleton St., Brown Blg., Room 401, Columbia, SC 29201 Phone: 803.734.1900 Fax: 803.734.2261

Today's Date ______/______/______

Victim's Legal Name ______________________________ Claimant *(if a different person)* ______________________

SS # (last 5 digits) ___ - ___ ___ ___ ___ Crime Date ___/____/_____

To the Provider: This form is used for consideration with the initial 14 mental health session's limit. To request approval/preauthorization for payment of additional sessions, the 'Additional Counseling Sessions Request Form' must be submitted.

This form must be submitted to request approval/preauthorization for payment of counseling sessions. The treatment must be directly related to the crime on which the claim is based. The information provided must include a goal-directed treatment plan and a summary of your assessment toward meeting those goals.

Approval/preauthorization is contingent upon the rationale behind the need and the details provided.

Is the trauma and the treatment a direct result of this crime? YES ________ NO _________

Presenting Issue: ____

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Description of psychological trauma as related to victimization: ______________________________

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Type of evidence based treatment model being used: ______________________________

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Payer of Last Resort Status:
The State Office of Victim Assistance is the payer of last resort. If the victim has insurance, and the victim elects not to use his/her insurance for treatment, SOVA 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, SOVA will pay after the insurance pays. Please provide the following information along with a copy of the EOB for each DOS:

Heath Insurance Carrier ______________________________ Policy No. ______________________

______________________	______________________	(_______)______________
Authorized Signature of Treating Therapist/Counselor	**Printed Name of Payee**	**Telephone No./Extension**
______________________	______________________	______________________
License Type and Number	**Mailing Address**	**City/State/Zip Code**
______________________	______________________	______________________
Supervisor's Signature	**License Type and No.**	**Date**