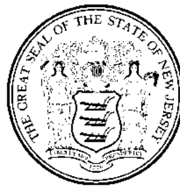

PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

State of New Jersey
OFFICE OF THE ATTORNEY GENERAL
DEPARTMENT OF LAW AND PUBLIC SAFETY
DIVISION OF CRIMINAL JUSTICE
VICTIMS OF CRIME COMPENSATION OFFICE

50 Park Place
Newark, NJ 07102
Telephone: (973) 648-2107 Fax: (973) 648-3937
Website: www.njvictims.org Email: njvictims@njvictims.org

MATTHEW J. PLATKIN
Acting Attorney General

LYNDSAY V. RUOTOLO
Director

MARY ELLEN BONSPER
VCCO Director

Physician's Certification

Re: Patient:
Social Security No.:
Account No:
Date of Service:
Date of Birth:
Our Claim No.:

Dear Sir/Madam:

A claim for crime victim compensation concerning the above named individual has been filed with the Victims of Crime Compensation Office of the State of New Jersey. Attached is a copy of the Authorization to Obtain Records.

Note: The New Jersey Victims of Crime Compensation Office is NOT covered by HIPAA. Compensation programs like the VCCO are not "covered entities" under HIPAA which protects patient confidentiality. For HIPAA purposes, the VCCO is a "payer" to which disclosures may be made without prior authorization.

Could you please help us process this claim by providing copies of the following:

SECTION 1 - TREATMENT

1. Dates of Treatment - From: _______ To

2. Describe the nature and extent of the injury and treatment provided: (or attach reports of injury and treatment).

SECTION 2 - DISABILITY

1. In your medical opinion, was the treatment you provided a direct result of the crime as reported by the patient? Yes [ ] No [ ] (If no, please explain)

2. In your medical opinion, did the injuries from the reported crime aggravate or accelerate a pre-existing condition? Yes [ ] No [ ] (If yes, please explain).

3. In your medical opinion, did the patient's physical or emotional injuries disable the patient from work? Yes [ ] No [ ]

4. Is the patient still unable to work? If no, what is the date that the patient should have returned to work? Yes [ ] No [ ] Date:

5. May the person work under some limitation? Yes [ ] No [ ] If yes, what are those limitations.

6. Do you expect any further treatment will be required for this patient? Yes [ ] No [ ] If yes, can you estimate the length of treatment: Dates

SECTION 3 - CERTIFICATION

I certify that the above report truly and correctly sets forth the history, diagnosis and opinion. I am a practitioner licensed in and practicing in NJ. My License Number is:

PRINT NAME **SIGNATURE**

TITLE **PHONE NUMBER** **DATE**

CERTIFICATION FOR RECORDS SUBMITTED TO THE VICTIMS OF CRIME COMPENSATION OFFICE

I hereby certify that the attached records consisting of (*ie: medical records of John Doe, police report regarding incident on 1/1/11*):

____, are true, accurate and complete copies of the original records on file in this office.

I certify that these records were maintained in the regular course of business by (*insert name of business/government entity*):

______________________________. I further certify that such records are maintained at or near the time of the relevant event.

I certify that I have knowledge as to the authenticity of these records and that I have the responsibility of maintaining their custody.

I certify that the foregoing statements made by me are true and correct to the best of my knowledge. I am aware that if any of the foregoing statements made by me are willfully false, I may be subject to punishment.

______________	________________________
Date:	**Signature:**

Print name: ________________________

Title or Position: ________________________