

CRIME VICTIMS' COMPENSATION PORTAL TUTORIAL



CRIME VICTIM &
SURVIVOR SERVICES
DIVISION

Child Advocacy Centers

The purpose of this document is to provide guidance on how child advocacy centers can best use the Crime Victims' Compensation Portal.

Updated 3/18/20

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Crime Victims' Compensation Portal Tutorial

CHILD ADVOCACY CENTERS

PORTAL USE

The portal gives Child Advocacy Centers the ability to assist victims and applicants with applying for Crime Victims' Compensation (CVC) benefits, submit bills and securely uploading medical chart notes.

From the portal, you can:

- Submit an application
- Search for claims using a claim number or the victims name and date of birth
- View claim status and payment information
- View insurance information
- Upload bills, EOB's, and chart notes
- E-mail claim specialist and examiner

All CVC applications must include the electronic or uploaded signature of the victim/applicant to be processed.

PORTAL ACCESS

1. Register for portal access at: <https://justice.oregon.gov/victims/compensation/Account/Login>.
2. Click on "Register".
3. Select "Advocate" as your role.
4. Enter your information and create a password.
5. Click on "Register".
6. Wait for a message stating that your registration was approved, then confirm your e-mail.

Things To Know

- Once you have submitted your registration, CVSSD will review and approve your access. This will take between one and three business days.
- You must use your work email address to register.
- Once your access has been approved, confirm your e-mail.
- If multiple people will be assisting with applications and uploading documents it is recommended that you use a common email and log in.

SUBMITTING AN APPLICATION

Child Advocacy Center representatives may assist the victim (or, if a victim is a minor or deceased, the guardian) in filling out an application.

Application Options

1. **Crime Victims' Compensation Application** should be used when the crime has been reported to law enforcement, the victim is a child, and/or the victim is deceased.
2. **Children's Advocacy Center "No Signature" Billing Form** should be used when a Center provided services but was not able to obtain a signed "Release of Information" from the patient or guardian (for specific reasons).

APPLICATION ACCESS

1. Login to the portal - <https://justice.oregon.gov/victims/compensation/Account/Login>.
2. Select "File An Application".



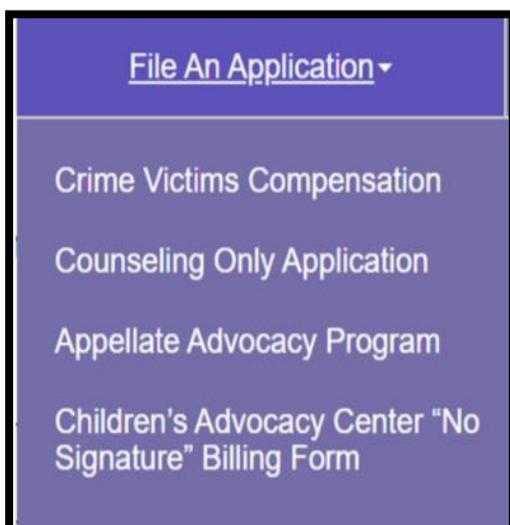
OREGON DEPARTMENT OF JUSTICE
Crime Victim and Survivor Services
Reducing the impact of crime on the lives of victims and survivors

Tutorial for Service Providers How Do I Search Claims **File An Application ▾**

Type of Claims
Crime Victims Compensation: If you were the victim of a person crime in the state of Oregon.
[More Types](#)

Quick Help
View a Claim: Search by Claim Number

3. Select "Crime Victims' Compensation" or "Children's Advocacy Center "No Signature" Billing Form".



File An Application ▾

- Crime Victims Compensation
- Counseling Only Application
- Appellate Advocacy Program
- Children's Advocacy Center "No Signature" Billing Form

CRIME VICTIMS' COMPENSATION APPLICATION: REQUIRED INFORMATION

All required fields are highlighted in yellow.

Who referred you to our program?

Who referred you to our program?		
<input type="checkbox"/> Police	<input type="checkbox"/> Victim Assistance Program	<input type="checkbox"/> Medical Provider
<input type="checkbox"/> Tribal Advocate	<input checked="" type="checkbox"/> Child Abuse Assessment Center	<input type="checkbox"/> Other: <input type="text"/>
Select Assessment Center <input type="text" value="Select Assessment Center"/>		
You are filing this application because you are (check one):		
<input type="checkbox"/> The victim of a crime	<input type="checkbox"/> The parent or guardian of a crime victim under 18 years of age	<input type="checkbox"/> The parent or guardian of adult victim who can't apply on their own
<input type="checkbox"/> A family member of a victim who died as the result of the crime	<input type="checkbox"/> Other (explain): <input type="text"/>	

➤ Select "Child Abuse Assessment Center " and the name of your organization from the dropdown list.

Victim Information

Victim Information (Person who is injured or deceased)					
First Name:		Middle Name:	Last Name:		
Mailing Address:	Apt #:	City:	State: Oregon	Zip:	
Phone:	Social Security Number:		Language Spoken: English		
Date of Birth:	If victim is deceased, date of death:			Gender: Please Select	
May we contact you by email?		If yes, please provide your email address:			
No					

➤ The victims' information is always required.

Victim Address

If a child victim is in DHS custody: add the address of the DHS office that the child's case worker works from.

Social Security Number: it is not required to process a claim. CVSSD does not look at legal status at any time during the life of a claim

E-Mail: If the victim/applicant prefers to be contacted by e-mail please make sure to provide the e-mail address.

Applicant Information (Legal Guardian)

Applicant Information <small>(Parent or Guardian of injured victim, or family member of deceased victim)</small>				
First Name:		Middle Name:		Last Name:
Mailing Address:	Apt #:	City:	State: Oregon	Zip:
Phone:	Social Security Number (see page 8):		Language Spoken: Select a Language	
Date of Birth:	Gender: Select a Gender	Your relationship to the victim		
May we contact you by email? No		If yes, please provide your email address:		

- The applicant's information is required when the child is under the age of 14. In these cases the required fields will become highlighted in the section.

Crime Information

Crime Information <small>(Required for all claims)</small>				
Type of Crime:		Select Type of Crime		
Did the crime involve a vehicle?:		Please select		
Alleged Suspect (if known):		Date of Birth:		
First Name:		Last Name:		Date of Birth:
Additional Suspect (if applicable):		Date of Birth:		
First Name:		Last Name:		Date of Birth:
Date of Crime:	Date Reported:	Report Number:		
Name of Police Department reported to: Select Police Department		Name of Officer:		
Was the crime reported within 72 hours?		No		
If No, please explain why (required):				
Location of Crime:	City:	State: Oregon	Zip:	County: Select County
Reports to be provided by Child Assessment Center (Please check ALL that apply)		<input type="checkbox"/> Forensic Interview <input type="checkbox"/> Medical Assessment		

- CVSSD asks that you enter as much crime information as possible but only the required fields (highlighted yellow) are needed to submit the application.

Crime Information

- Type of Crime:** Select the type of crime that best fits the incident.
- Did the crime involve a vehicle?** Mark "yes" if a vehicle was involved or if the victim was in a vehicle when the crime occurred. If "yes", the victim must submit a claim to their auto insurance.
- Alleged Suspect:** If the suspect is unknown, type "unknown" in the first and last name fields.
- Date of Crime:** Add the date if known. While this is not required, it is helpful information for CVCP to have when processing the claim.
- Name of Police Department:** Select the law enforcement agency that received the report of the crime.
 - If the crime was reported to the Department of Human Services, select "DHS".
- Location of Crime:** This can be an address, intersection, or business name. Be as specific as possible.
- Reports to be provided by CAC:** Please select "Forensic Interview" or/and "Medical Assessment". CVCP needs to know what type of report the Center will provide.

How can we help you?

How can we help you?			
Check all that apply			
<input type="checkbox"/> Medical	<input type="checkbox"/> Counseling	<input type="checkbox"/> Loss of Earnings	
<input type="checkbox"/> Dental	<input type="checkbox"/> Physical Rehabilitation	<input type="checkbox"/> Transportation	
(For homicide claims only):		<input type="checkbox"/> Funeral	<input type="checkbox"/> Loss of Support
		<input type="checkbox"/> Survivor Counseling	
Was the victim employed at the time of the crime and applying for loss of earnings or loss of support?			Please Select ▼
Name of Victim's Employer:	Address:	Phone:	Returned to work? Please select ▼
Did you miss more than two weeks of work?			Please Select ▼
Name of Victim's Doctor:	Address:	Phone:	Date returned to work:
Do you have any of the following to help with Loss of Earnings or Support?			
<input type="checkbox"/> Sick Pay or Disability through employer		<input type="checkbox"/> Social Security	
<input type="checkbox"/> Workers' Compensation			

- The “How can we help you?” section only requires you to report if the victim was employed at the time of the crime. If “yes” is selected, the employers’ information becomes required. If the victim missed more than two weeks of work, the doctors’ information will become required.

Injuries and Expenses

Injuries and Expenses					
Please describe your injuries (including mental trauma) resulting from the crime:					
Have you had any medical treatment or counseling as a result of the crime? Please list providers seen for crime-related injuries or trauma, paid or unpaid.					No ▼
Provider Name	Address	City	State	Zip	Phone Number
			Select a State ▼		
			Select a State ▼		
			Select a State ▼		

- This section is not required. The “describe your injuries” field provides space for you to add information that you would like to share with CVSSD.

Insurance Information

Insurance Information	
(required for all claims)	
Please check ALL that apply to the victim at the time of the crime, or as the result of the crime. List insurance company and other resource information below. (use additional pages if necessary)	
<input type="checkbox"/> Private Health Insurance	<input type="checkbox"/> Medicare
<input type="checkbox"/> Oregon Health Plan	<input type="checkbox"/> Workers' Compensation
	<input type="checkbox"/> Dental
	<input type="checkbox"/> None
Insurance Company Name:	
Do you have auto insurance?	No ▼
If yes, Auto insurance name	Claim #

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

*If the victim has private insurance, the name of the insurance company is required.

*If a vehicle was involved in the crime, the auto insurance section is required.

Optional Contact

Optional Contact Person

(Person we can talk to about your claim)

First Name:	Middle Name:	Last Name:
Contact person's phone:	Contact person's relationship to the victim:	Language Spoken:

- The optional contact person is a person who the victim or applicant gives CVCP permission to discuss their claim. CVCP will not be able to talk to any person not listed in this section. If preferred by the victim, this person could be the primary point of contact for CVCP.

Optional Contact

Examples of optional contact include:

- Other parent
- Family member
- Close Friend

Additional Counseling

Additional Counseling

Did anyone besides the victim receive or will be requesting counseling because of the crime? (Homicide Survivor Counseling, Child witness to domestic violence, family member of child victim of sex abuse)			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			

- Family members of child abuse victims may be eligible for counseling benefits under CVC. For each family member, include their name, date of birth, relationship to the victim, and insurance insurance carrier.

Additional Counseling

This section is for immediate family members of:

- A victim of child sexual abuse,
- A victim of physical abuse,
- A deceased victim,
- A child witness to domestic violence

If you need more details on how many sessions are authorized please contact the claim specialist.

Advocate Contact Information

Advocate Contact Information (Person who is assisting victim with application)		County: Marion	
Advocate name: Cecilia	Lucero	Advocate e-mail: cecilia.v.lucero@doj.state.or.us	Advocate phone#: 503-378-6269

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

Submit

Submit

- Once all the required fields (highlighted yellow) are complete, click “submit”.

Possible Errors

- If you missed a required field you will be redirected back to that section.

You must check at least one who referred you checkbox.

Who referred you to our program?

Police

DA Office

Medical Provider

Other:

You are filing this application because you are (check

- **Signature Error:** The signature must match the name of the victim or applicant exactly.
 - Extra spaces in the name fields in the victim/applicant section cause the most problems. Make sure to remove any extra spaces.
 - If a middle name is listed on the form, it must also be included in the signature.

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: 10/14/2019

The signature must match either the victim or the applicant.

Signature of 14-17 year old: Date:

Application Submitted

Your Online Web Claim Submission has been submitted. Your Online Submission Id is 62309.
Please allow 3 - 5 days to access claim.
If you have any questions email: cvssportal@doj.state.or.us
Go Back to [My Claims](#)

- Immediately after submitting the application you will receive confirmation and the submission ID.
- As a CAC, you will have access to claims you have submitted under the Claims Submissions section.
- Within 2 days you will receive an email notification from CVC that will give the claim number so that documents (reports, signature pages, bills etc) can be uploaded.

CHILDRENS ADVOCACY CENTER "NO SIGNATURE" BILLING FORM

CAC Name and Date of Service

CAC/CAIC Name:	Liberty House	Date of service:	
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- The CAC name is auto populated from your portal profile.
- Enter the date services were rendered.

Patient Initials and Account Number

Patient Initials:	
Account Number:	

- Do not use a full name or more than one letter of each name for the initials. Providing a full name or partial name can be a breach of confidentiality.
- The account number should be a number that is linked to the date of service and not the patient. This number can only be used once in our system and duplicate numbers will be rejected even if the date of service is different.

Additional Patient Information

Patient was referred due to concerns of : **Please Select** ▼
Did the patient disclose abuse? (Please do not provide further information.) : **Please Select** ▼
Why was the guardian signature not obtained?(This form can only be submitted for one of the three reasons listed.) **Please Select** ▼

- Unless requested by CVC, do not provide additional details or information for these questions.

Insurance Information

INSURANCE INFORMATION

Does the patient have insurance? Yes

If insurance was not billed because the insurance subscriber is the alleged suspect check here

Did insurance pay all or part of the bill?: Please Select

If yes, any portion of the bill that remains must be written off by the CAC. Victim should not be billed. CVC cannot pay the remainder without a "Release of Information" from the patient or guardian.

If no, why was the bill denied? : Please Select

- If the patient does not have insurance, this section is not required
- If the patient has insurance, but the insurance could not be billed because the alleged suspect is the subscriber, please indicate by answering the first two questions. The rest of the section is not required.
- If the patient has insurance and it was billed, please complete this section in full.

Billing Information

BILLING INFORMATION

(The name and credentials of the provider who perform the assessment are required. CVC will still use the workers compensation fee schedule when processing payments)

Name of Provider Rendering Services	Credentials
<input type="text"/>	<input type="text"/>

Codes billing (Enter the billed amount per code for the services rendered to the patient.):

92551	<input type="text"/>	99170	<input type="text"/>	99173	<input type="text"/>	99205	<input type="text"/>
99354	<input type="text"/>	99355	<input type="text"/>	99499	<input type="text"/>		

Total Billed Amount:\$0.00

- The name and credentials for the provider who rendered services is required.
- Enter the billing amount for each applicable service code.
- CVC uses the Workers' Compensation fee schedule when processing payments.

EXPLORING THE PORTAL

CLAIM SEARCH

You have three ways to search for claims.

1. Under Claim Submissions (if you assist the victim/applicant in filling out an application through your profile, you will see the claim in this section.) Use the filter to search to reduce the number of claims in your view.

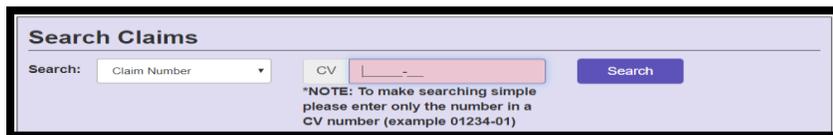


The screenshot shows a table titled "Claim Submissions" with a filter input field and a "Show 10" dropdown. The table has columns for Edit, Claim Number, Online Submission Id, Submission Date, Victim, Application Status, and an icon column. One row is visible with the following data:

Edit	Claim Number	Online Submission Id	Submission Date	Victim	Application Status	Icon
		52262	09/03/2019	cecilia test	Submitted	+ 🗨

- **Claim Number:** The number CVC assigns to a victim's application.
- **Online Submission Id:** The number given as a reference for the application that was submitted until a claim number is generated.
- **Submission Date:** Date the application was submitted.
- **Victim:** The name of the victim.
- **Application Status:** Status of the application
 - **Submitted:** The application has been submitted to CVC but has not yet been imported into the CVC system.
 - **Received:** The application was received by CVC and assigned a claim number.
 - **Rejected:** The application was rejected by CVC.

2. By the claim number (only enter the digit part of the claim number).



The screenshot shows the "Search Claims" form with a dropdown menu set to "Claim Number" and a "CV" input field containing "1234-01". A "Search" button is visible. A note below the form reads: "NOTE: To make searching simple please enter only the number in a CV number (example 01234-01)".

3. By patient's name and date of birth (you must have both).



The screenshot shows the "Search Claims" form with a dropdown menu set to "Name & Date of Birth". There are input fields for "Name" and "Date of Birth", and a "Search" button.

The search results will populate below the search claim area

	Claim Number	Victim	Claim Determination Status	Date Received	Claim Expiration Date	Assigned Examiner	Assigned Specialist	Status
Select Claim	CV 04079-15	Doe - ADULT, Jane	Claim accepted	10/14/2015	03/28/2022	Christy	Sara	z-Test Claim

Showing 1 to 1 of 1 entries

Search – Field Explanation

- 1. Claim Number:** The number CVC assigns to a victim’s application.
- 2. Victim:** The name of victim/patient.
- 3. Claim Determination Status:** The status of the claim (accepted or denied)
- 4. Date Received:** The date when the application was received.
- 5. Claim Expiration Date:** The date when the claim will expire.
- 6. Assigned Examiner:** The person who determines eligibility.
- 7. Assigned Specialist:** The person assisting in processing bills & requesting information.
- 8. Status:** Status of the application:
 - **Pre-determined:** CVC is still reviewing the claim.
 - **Inactive:** No activity on the claim
 - **Open-Accepted:** Actively working bills and requesting information.
 - **CAC no Signature:** Signature page was not received and CVC cannot continue processing.

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.

CV 05029-07 Claim Detail Payments Forms Claims Search

Claim Detail

Victim: Doe, Jane
 Claim Number: CV 05029-07
 Date Received: 07/11/2017
 Status: Predetermined
 Claim Expiration Date: 06/06/2021
 Date Of Crime: 12/17/2007
 Referred By: Child Assessment Center
 Examiner Assigned: Christy
 Specialist Assigned: Christy
 Reported To: Marion County Sheriff's office
 Date Reported: Marion
 Crime County: Marion
 Determination Status: Claim accepted
 Determination Date: 06/06/2018

Insurance

Filter:

Organization Name	Type	Effective Date	Policy Number
OHP	Current Health Insurance	1/1/2017 12:00:00 AM	ZB23651B
Blue Cross Blue Shield of Idaho	Current Health Insurance	1/1/2017 12:00:00 AM	

Showing 1 to 2 of 2 entries

Claim Info – Field Explanation

Insurance Information Section: The name of the current insurance company, the effective date, and the policy number (OHP ID will be shown as well).

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 tapping on the "Payment" tab, you will see the payments made under the claim.

Detail	Pay To	Transaction Type	Provider Name	Amount Paid
Detail	Western Psychological & Counseling - Corporate	Counseling	Western Psychological & Counseling - Corporate	\$30.00
Detail	Western Psychological & Counseling - Corporate	Counseling	Western Psychological & Counseling - Corporate	\$425.00
Detail	Providence St Vincent Medical Center-payments	Hospital	Providence St Vincent Medical Center-payments	\$200.00
Detail	Providence St Vincent Medical Center-payments	Hospital	Providence St Vincent Medical Center-payments	\$19,424.20
Detail	West Valley Fire District	Ambulance	West Valley Fire District	\$777.00

Payment – Field Explanation

- Detail:** When clicking on "detail" more information will be shown for that specific payment.
- Pay To:** This is the person or provider who the payment was made to.
- Transaction Type:** This is the type of service that the victim received.
- Provider Name:** Name of the provider who provided services.
- Amount Paid:** This is the amount CVSSD paid.

Payment Detail

Click on "detail" of the payment you would like more information on.

Pay To:	Western Psychological & Counseling - Corporate
Date Service Started:	02/15/2017
Date Service Ended:	03/09/2017
Provider Name:	Western Psychological & Counseling - Corporate
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

- Amount Billed:** Please note that our program does bundle payments.
- Paid By Prior:** This amount shows the victims insurance payment and deductible.
- Fee Schedule:** This amount is a provider write-off that must be taken if the provider accepts our payment.
- Other Deductions:** If victim made out-of-pocket payments or restitution was paid to the provider or victim the amount would be noted here.
- Date Authorized:** This is the date the payment was authorized and sent to fiscal for payment processing.
- Check Comments:** May include counseling hours remaining, etc.
- Amount Paid:** This is the amount CVSSD paid.

Forms

Our program will be adding forms. The “Getting Started with Crime Victims” is information about CVC.

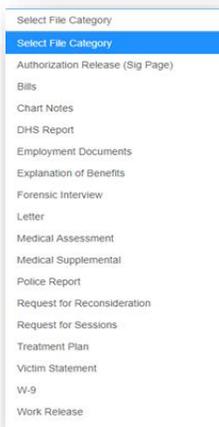


CV 04079-15 Claim Detail Payments **Forms** Claims Search

Getting Started with Crime Victims (English)
Getting Started with Crime Victims (Spanish)

DOCUMENT UPLOAD

You are able to upload reports, signature pages, bills, chart notes, EOB's, or any other documentation you would like CVSSD to review.



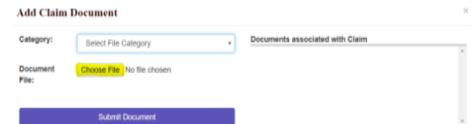
Select File Category

- Select File Category
- Authorization Release (Sig Page)
- Bills
- Chart Notes
- DHS Report
- Employment Documents
- Explanation of Benefits
- Forensic Interview
- Letter
- Medical Assessment
- Medical Supplemental
- Police Report
- Request for Reconsideration
- Request for Sessions
- Treatment Plan
- Victim Statement
- W-9
- Work Release

This is the upload icon that can be found 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” – this will allow you to browse your computer for the document you will send to us.
 - Same document types (for same claim) can be combined into one document instead of one at a time for easier upload.
4. Click on Submit.



Add Claim Document

Category: Select File Category Documents associated with Claim

Document File: Choose File (No file chosen)

Submit Document

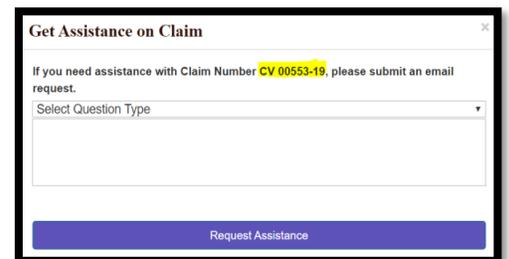
CONTACTING OUR STAFF

If you have questions in regard to a specific claim you can contact our staff through the portal.

This is the message icon that can be found throughout the portal



1. Select the message icon for the appropriate claim.
2. Select the type of question from the drop-down 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 1 to 2 business days for a staff member to respond.

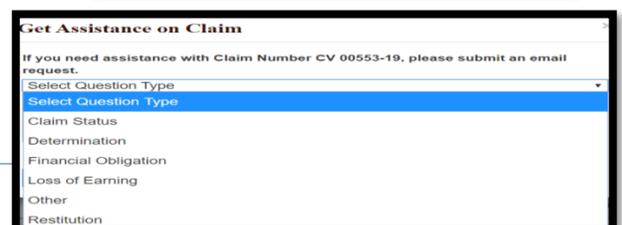


Get Assistance on Claim

If you need assistance with Claim Number CV 00553-19, please submit an email request.

Select Question Type

Request Assistance



Get Assistance on Claim

If you need assistance with Claim Number CV 00553-19, please submit an email request.

Select Question Type

Select Question Type

- Claim Status
- Determination
- Financial Obligation
- Loss of Earning
- Other
- Restitution

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 us at 503-378-5348 or cvssd@doj.state.or.us.

Required Information

For CVC to process a submitted bill, we will need the following information for review:

- **Billing Statement, HCFA, UB92:** The procedure codes, charge amounts and date of service must be included.
- **Copy of Explanation of Benefit:** If the patient has insurance (including OHP), the insurance must be billed as primary.
- **Medical Assessment:** Reports for the dates of services must be submitted.

If information is missing or additional information is required, CVC will send a request. Please respond to our request in a timely manner to avoid payment being denied.

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 insurance must be billed as primary. The provider must submit the explanation of benefits (EOB) to CVC. Insurance must be billed 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, a Workers' Compensation Fee Schedule will be applied. By law, the provider cannot bill the patient for the fee schedule (write-off).

Counseling

- Chart notes are not required for counseling sessions unless requested by CVC.
- A treatment plan is required after 15 sessions.
- Therapist must be licensed.
- Therapy is reimbursed 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 be reimbursed by CVC 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.

If you have any questions regarding the portal,
please send an e-mail to CVSSDPortal@doj.state.or.us