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| --- | --- | --- |
|  | Company: | Click or tap here to enter text. |
|  | Provider name: | Click or tap here to enter text. |
|  | Mailing Address: | Click or tap here to enter text. |
|  | City, State, Zip: | Click or tap here to enter text. |
|  | Telephone number: | Click or tap here to enter text. |
|  | Email: | Click or tap here to enter text. |

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| Invoice |

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| **TO:** |  |  |
| Crime Victim Compensation |  |  |
| 1000 Judicial Center Drive, Ste 100 | CVC claim number: | Click or tap here to enter text. |
| Brighton, CO 80601 | Patient/Client name: | Click or tap here to enter text. |
| Email: [vcomp@da17.state.co.us](mailto:vcomp@da17.state.co.us) | Patient/Client DOB: | Click or tap here to enter text. |
| Phone: 303-835-5690 |  |  |
| Fax: 303-835-4165 |  |  |

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| **DATE OF SERVICE** | **SERVICE TYPE** | **CPT Code** | **COST** |
| Click to enter a date. | Click to enter text. | Click to enter text. | Click to enter text. |
| Click to enter a date. | Click to enter text. | Click to enter text. | Click to enter text. |
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| Click to enter a date. | Click to enter text. | Click to enter text. | Click to enter text. |
|  |  | TOTAL: | Click to enter text. |

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| I have billed this client’s insurance (Attach EOBs) |
| I am not a provider for this client’s insurance |
| This client does not have insurance available. |
| This client has paid for these dates of service – Please reimburse the client. (Attach receipt or verification of payment). |
| Dates of service are unpaid – Please pay the provider. |