Kansas Sentencing Commission

# Offender Insurance Coverage Report Form

*Detailed Accounting of SB 123 Offenders*

KSC Use Only

Treatment Provider Name: _____
Billing Address: _____
_____
_____
Name of Preparer: _____
Telephone Number: _____

Name of Insurance Provider: _____

Offender Name: _____
KDOC Number: _____
Court Case Number: _____
County: _____

Service Location: _____
(If Different than Billing Location)

☐ All Insurance Claims Denied by Insurance Provider (Documentation of Denial Must Be Attached)

| Treatment Modality | Units of Treatment | Cost Per Unit | Total Cost of Treatment | Amount Paid by Insurance Provider | Remaining Treatment Cost |
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| | | | | | |
| | | TOTAL | | | |

Attach this form to the "Invoice for Purchase of Service" form for every offender with third party insurance coverage, including Medicaid and Medic