Offender Insurance Coverage Report Form

Detailed Accounting of SB 123 Offenders

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 Partial/Denial Must Be Attached with invoice)**

Treatment Modality	**A**. Service Units (box 17)	**B**. $Cost/Unit (box 18)	**C**. = A x B $Total (box 19)	**D**. Amount Paid by Insurance Provider	**E**. = C - D Remaining Treatment Cost
			TOTALS		
				(box 20)	(box 21)

Attach this form to the "Invoice for Purchase of Service" form for <u>every offender with third party insurance coverage</u>, including Medicaid and Medicare