

GEORGIA CRIME VICTIMS COMPENSATION PROGRAM
CRIMINAL JUSTICE COORDINATING COUNCIL

104 MARIETTA STREET, SUITE 440 ★ ATLANTA, GEORGIA 30303-2743
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Itemized Bill Example

This enclosure outlines the Crime Victims Compensation Program’s description of an itemized bill. To proceed with the verification process on a bill, the bill **MUST BE ITEMIZED**. Therefore, if an itemized bill is requested, please send a bill that provides the following information:

1. Provider(s) name, address and phone number.
2. Account number (if applicable).
3. Date(s) of Service (actual date services were provided).
4. A description of all the services provided (e.g. x-ray, replaced tooth, operating room, etc.)
5. Charges for each service provided.
6. Total charges and/or balance due.

1. Provider Information

2. Account Number

ABC Hospital, LLC
 1234 Your Street
 Anywhere, Georgia 30005
 (404) 555-4455 phone
 (404) 555-5544 fax

Account: 00010001000

Bill to: Patient/Guardian's Name
 4321 Next Street NW
 Anywhere, Georgia 30005

<i>Date of Service</i>	<i>Description/Code</i>	<i>Amount</i>
01/01/2009	Intravenous Medication/0001	\$100.00
01/01/2009	Operating Room/00022	\$10,000.00
01/01/2009	Recovery/000333	\$1,000.00
01/01/2009	Room 100	\$1,100.00

Total Charges \$12,200.00

Adjustments/Insurance - \$1,200.00

Balance Due \$11,000.00

3. Dates of Service

4. Description of Services

5. Cost per Service

6. Total Charges & Balance Due