BILL BALANCE VERIFICATION
JD-VS-51 New 12-21

STATE OF CONNECTICUT
OFFICE OF VICTIM SERVICES
JUDICIAL BRANCH
www.jud.ct.gov/crimevictim

Instructions
1. Complete the form.
2. Attach to the original bill and forward this form and original bill to Accounts Payable.

Record number (if applicable)	Claim number	Claims Examiner name	Date verified

Provider name	Account number

Name of person at Provider verifying bill	Phone number

Name of insurance company, if applicable	Date(s) of service

Forms to be obtained from provider	Name of person to complete forms	
☐ W-9 ☐ SP-26		
Fax number	E-mail	Date provided to fiscal administrative support

Total charges	$
Collateral payments	$
Provider adjustment	$
Patient/claimant payment	$
OVS adjustment	$
Balance owed	$

☐ deductible ☐ co-insurance ☐ no-insurance
☐ maxed ☐ no out-of-network benefits

☐ out-of-network
☐ in-network

Additional Notes

THE INFORMATION ON THIS FORM HAS BEEN FILLED OUT AND VERIFIED BY OVS STAFF

Print Form Reset Form