VICTIM CLAIM FORM

Northampton County Juvenile Probation Department

IMPORTANT
Restitution may not be ordered, if no reply within 30 days from

_____

In the matter of: _____
Probation Officer: _____
Incident Date: _____
Incident: _____

MEDICAL OR MENTAL HEALTH EXPENSES

(Please list all medical or mental health treatment you received)

DATE	NAME OF DOCTOR OR PROVIDER	TREATMENT	AMOUNT
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
		TOTAL	$

Victim's Name: _____

Victim's current address: _____

Victim's current telephone number: _____

Above loss covered by insurance: Yes ☐ No ☐ In part ☐

Amount of Claim presented to Insurance Company $_____

Amount of Claim paid by the Insurance Company $_____

What is your deductible? $_____

Insurance Co.: _____ Claim Representative: _____

Address: _____

Telephone #: _____ Policy Holder: _____

Policy #: _____ Claim #:_____

THE FACTS SET FORTH IN THE FOREGOING ARE TRUE AND CORRECT TO THE BEST OF THE UNDERSIGNED'S KNOWLEDGE, INFORMATION AND BELIEF AND ARE VERIFIED SUBJECT TO THE PENALTIES FOR UNSWORN FALSIFICATION TO AUTHORITIES UNDER 18 PA.C.S.§4904

DATE: _____ SIGNATURE: _____