CB Form-20 (Revised 9/16)

DATE: _____

TO: Compensation Board

FROM: _____
_____
_____

SUBJECT: Request for reimbursement of medical emergency services rendered to _____, a State Responsible* inmate.
(Name of Inmate)

*State Responsible Inmate – any individual that is fully sentenced on one or more felony charges with a net sentence length of 1 year or more for offenses committed on or after 1/1/1995 or more than 2 years for offenses committed before 1/1/1995.
State Responsible Inmate becomes eligible for emergency medical expense reimbursement beginning on the sixty-first day following the date of mailing by certified letter or electronic transmittal by the clerk of the committing court to the Director of the Department of Corrections (DOC). The date of mailing/transmittal date is specified by the DOC and identified in CORIS as the "court order mailed/faxed date". This date will be verified by Compensation Board staff in order to verify eligibility for reimbursement.

1. CORIS-ID: _____

2. Offense Date: _____

3. Dates of current incarceration: From _____To_____

4. ***Sentence Date*** of prisoner's final felony conviction or disposition date of last disposed offense.

   _____

5. <u>To be completed by facility's LIDS Technician ONLY:</u>
   Was prisoner State Responsible and more than 60 days past the date of the final sentencing order on dates shown below when services were rendered by medical provider?* YES NO (circle)
   *__Note__ that Compensation Board staff will make final determination of eligibility based upon the DOC identified "court order mailed/faxed date", which may be later than the date of the final sentencing order.

   LIDS TECHNICIAN SIGNATURE:_____
   DATE:_____

6. Date of Service Provider Amount

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
	TOTAL	_____

7. Has another request for reimbursement of medical bills been filed on this individual? YES NO (circle) If "yes", please provide dates of submission: _____

8. Total amount that has been spent by your locality for medical supplies for the jail and for medical services performed by hospitals, doctors, etc. outside your facility (this total should include expenses incurred for ALL other such emergencies since July 1 of the current fiscal year to date): $_____

9. Total dollar amount budgeted by your facility for medical supplies and emergencies for the current fiscal year: $_____

I certify the above information is correct to the best of my knowledge and the expenses requested for reimbursement have been presented to the locality for payment.

_____ _____
Date Sheriff/Jail Superintendent

I certify the expenses requested for reimbursement have been paid by the locality.

_____ _____
Date Chief Disbursing Officer

Please retain an original copy of this form on file to use each time a request is made.

The Compensation Board will not consider the request for reimbursement unless certification that the expenses incurred have been paid by the jail/locality is included.

EXPLANATION OF ITEMS REQUESTED
ON CB FORM-20 (Revised 9/16)

HEADING

1. Date form is completed.

2. From: Name and address of Sheriff's Office, Jail Farm or Regional Jail submitting request.

3. Name of inmate who received medical services for which reimbursement is being sought.

SUBJECT

1. CORIS-ID as found in LIDS-CORIS.

2. Date of Offense for which inmate is sentenced as State Responsible.

3. Beginning and ending dates of incarceration during which the medical emergency occurred (if inmate is still incarcerated at the time of request, end date is "Present").

4. Date of inmate's final felony conviction or disposition date of last disposed offense.

5. Estimate eligibility for reimbursement of expenses incurred based upon date of sentencing; Compensation Board staff will make final determination of eligibility based upon transmittal date of final sentencing order to Department of Corrections for state responsible inmate as identified in CORIS pursuant to §53.1-20.1 Code of Virginia.

6. 1 – Date of Service for which reimbursement is requested
   2 - Provide the name of the doctor, hospital or professional providing medical service.
   3 - Amount of invoice or portion of invoice for which you are requesting reimbursement.

   NOTE: The information for Items 1, 2 and 3 is to be taken from the invoice and the information to be entered in these columns is to be a summary total of each invoice.

7. If you have previously filed for reimbursement for this inmate please indicate by responding "YES" and provide date of prior request.

8. Please indicate the total expenditures to-date in the current fiscal year by your locality/jail for medical supplies for the jail and for medical services performed by hospitals, doctors, etc. outside of your facility (i.e., this total should include expenses incurred for all other such emergencies since July 1 of the current fiscal year to date).

9. Total dollar amount budgeted for your facility for medical supplies and services (including emergencies) in the current fiscal year.

REIMBURSEMENT PROCESS

Emergency Medical Requests will be considered each year on the May and November Compensation Board meeting dockets.

Dental services, pharmaceutical expenses, and any/all services performed within the facility are not eligible for emergency medical reimbursement.

May Docket

In order to be eligible for consideration on the May docket, requests must be submitted **no later than May 1st**. Submissions for the May docket may only include requests for reimbursement of expenses incurred for dates of service, and/or invoices paid by the jail/locality, from November of the previous calendar year through April of the current calendar year.

November Docket

In order to be eligible for consideration on the November docket, requests must be submitted **no later than October 25th**. Submissions for the November docket may only include requests for reimbursement of expenses incurred for dates of service, and/or invoices paid by the jail/locality, from May of the current calendar year through October of the current calendar year.

For all expense reimbursements, **do not wait until the deadline to submit requests for reimbursement** during the period – submit requests when expenses are incurred for inclusion in the next upcoming cycle. Submitting a large volume of requests at the last minute may result in delays in reimbursement or a denial of the request for reimbursement if insufficient funding exists to reimburse all requests.

Backup Documentation

One individual, original form must be submitted for each inmate's expenses requested for reimbursement. Each request for reimbursement must include pages 1 and 2 of the form CB-20 plus an attached invoice copy identifying date of service, provider, cost for service paid by the jail/locality, and date/month of payment by the jail/locality. **Do not provide a single invoice copy for multiple inmates**. If multiple inmates appear on the same invoice, please attach a copy of that invoice to the CB20 form for each inmate.