TIMOTHY J. SHUGRUE
DISTRICT ATTORNEY

The Commonwealth of Massachusetts

BERKSHIRE DISTRICT ATTORNEY

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MEDICAL RESTITUTION FORM

Commonwealth vs. ________________________________ Docket #: ______________________

Victim Assistance Advocate: _________________________

Victim Name: _______________________________

A. Briefly describe injuries: ____
____
____

B. Medical Care Provider — Cost

____ $_____________
____ $_____________
____ $_____________

C. Please list miscellaneous medical expenses and describe (prescriptions, co-pays, etc.):

____
____
$_____________

Subtotal: **$**_____________
***Please deduct amount paid by insurance:** **$**_____________
Your total out-of-pocket medical expense: **$**_____________

*Name of responsible insurance company: ___________________________________
Is this: My insurance company _______ Defendant's insurance company ________

**Please attach copies of bills, estimates, or other proof of loss to the form and retain the originals.
If your insurance company made a payment, please attach a copy of the insurance company determination showing payment and your deductible, if any.

Signature: ____ Date: ___________________

Telephone #: ____