NEW YORK STATE | Office of Victim Services

NEW YORK STATE OFFICE OF VICTIM SERVICES
MEDICAL PROVIDER FORENSIC RAPE EXAMINATION
DIRECT REIMBURSEMENT CLAIM FORM (6/20)

* F R E – 0 1 *

INSTRUCTIONS: This form is to be used when a NYS licensed healthcare provider is directly billing the New York State Office of Victim Services (OVS) for reimbursement of costs associated with providing a forensic exam for a victim of sexual assault.

(1) Fill in all blanks on this form.
(2) Attach: Itemized bill and supporting documentation indicating SOEC Kit was used and/or HIV PEP Meds were provided, if applicable.

All Sections ONE through THREE **must** be completed

(3) Mail the completed form and all attachments to:
NYS Office of Victim Services
Attn: FRE Processing
80 S. Swan Street, 2nd Floor
Albany, New York 12210

SECTION ONE. VICTIM INFORMATION (TO BE COMPLETED BY MEDICAL PROVIDER)

Date of Crime _____ Location of Crime (City) _____ (county) _____ (State) _____

Victim's Name _____

Date of Birth _____ Social Security Number _____

SECTION TWO. BILLING PROVIDER INFORMATION (TO BE COMPLETED BY MEDICAL PROVIDER)

Billing Provider Federal I.D. Number 13-2655001 Date of Exam _____

Billing Provider Name KINGS COUNTY HOSPITAL Operator Certificate or Facility ID.# 70010164

Address 451 CLARKSON AVENUE City BROOKLYN State NY Zip 11203

Billing Department Contact Person JAI PERSAUD Phone Number (718) 245 - 2478

Was a Sexual Offense Evidence Collection (SOEC) Kit Used? ____ **No** ____ **Yes** **SOEC Kit Tracking #** **(Required once tracking is available)** _____

Were HIV PEP Meds Provided? ____ **No** ____ **Yes** **If yes:** ____ **7 Day Starter Pack** ____ **Full Regimen 28 Day Pack**

Please select one option above and indicate on attached invoice.

The billing provider and other service providers, by law, shall not bill the victim for these services. Payment made to the providers by OVS under the Direct Reimbursement Program shall be considered by all providers as payment in full.

SECTION THREE. VICTIM INSURANCE WAIVER (TO BE COMPLETED BY VICTIM/LEGAL GUARDIAN)

- The law requires that the victim be advised orally and in writing that they may decline to provide insurance information.
- I have been fully advised of the options of payment for the forensic exam and the outcomes resulting from my forensic payment decision. I understand that I may use private insurance benefits, including Medicaid, Medicare, HMO or any other insurance program for payment of the forensic exam provided to me. I have also been advised that I will have to use my private insurance if I file a claim with OVS for other medical services outside of the forensic exam.
  Initial your selection for Option #1, #2 or #3 below:

_____ **Option # 1** – I choose not to use my private insurance benefits but request that the OVS be billed directly. I decline to provide such information regarding private health insurance benefits because I believe that the provision of such information would substantially interfere with my personal privacy or safety.

_____ **Option # 2** – I do not have private insurance benefits and request that OVS be billed directly.

_____ **Option # 3** – I choose to use my private insurance benefits for payment, or I choose to pay for my care directly.

Victim/Legal Guardian Name (Print or Type): _____

Victim/Legal Guardian Signature: _____ Date: _____

Examiner Name (Print or Type): _____ Examiner (Signature): _____

Profession: _____ License # _____ Date: _____

If you have questions, call the NYS Office of Victim Services at (800) 247-8035 or (518) 457-8727.

NEW YORK STATE | Office of Victim Services

NEW YORK STATE OFFICE OF VICTIM SERVICES
MEDICAL PROVIDER FORENSIC RAPE EXAMINATION
DIRECT REIMBURSEMENT CLAIM FORM (6/20)

* F R E – 0 1 *

GENERAL INSTRUCTIONS

- Print legibly – illegible claims will be rejected and returned to the billing provider.
- Fill in all blanks on the form – fields left blank will result in the rejection of your claim.
- An itemized bill for services must be attached to each claim form. This bill should be in the same form and substance as that billed to NYS Medicaid; it must include a billable code and charge for each line item (e.g., it is not acceptable for "pharmaceuticals" to be listed as one item), the sum total of all charges, and a valid sexual assault or sexual abuse diagnosis code.
  - NOTE: Billable codes are subject to change. Make sure to use the most current codes.
- If a Sexual Offense Evidence Collection (SOEC) Kit was used and/or HIV Post Exposure Prophylaxis (HIV PEP) Medication was provided, the provider must include supporting documentation.
- Please see the "Supplemental Information" document on our website for additional guidance.

CLAIM FORM - SECTION ONE

- Fill in the date and location of crime including city, county and state. Do not use "unknown" or "not applicable/not available" in these fields.
  - NOTE: If the date of crime cannot be determined, please provide an approximation. This can be a month/year, season/year, or date range.
  - NOTE: If the sexual assault occurs in another state or country, please provide as much information as possible to determine a location of crime.
- Print the victim's name including the first and last name, the victim's date of birth including the month, day and year of birth and the victim's Social Security Number (SSN).
  - NOTE: If the victim does not have or will not share an SSN, you must indicate in this field why you are not providing an SSN. Examples include; "undocumented," "infant," "not issued," "not available," and "N/A."

CLAIM FORM - SECTION TWO

- This section is to be completed by the facility where the forensic exam is performed. This may be the hospital or other Article 28 health care facility, a clinic, a private physician's office, a child advocacy center, etc.
- Print the date that the forensic exam was performed including the month, day and year of the exam.
- Print the billing provider's federal tax identification number, billing provider name, operator certificate/facility ID#.
  - NOTE: If the facility is not a hospital or other Article 28 facility and does not have an operator's certificate or facility ID#, mark this field with "not applicable" or "N/A" and indicate the type of facility; i.e., "N/A – Child Advocacy Center."
- Print the name and telephone number of the billing department representative and the address of the billing provider. This is the address where all correspondence will be mailed.
- Indicate whether a Sexual Offense Evidence Collection (SOEC) Kit was used. You must indicate yes or no. If an SOEC Kit was used, you must include the SOEC Kit tracking information.
  - NOTE: If kit tracking is not yet available, you may indicate "N/A" in this field.
- Indicate whether HIV Post Exposure Prophylaxis (HIV PEP) Medication was provided. You must indicate yes or no. If HIV PEP was provided you must indicate whether it was a 7-day starter pack or full 28-day regimen.
  - NOTE: OVS reimbursement for HIV PEP will not exceed that of which is required under the law.

CLAIM FORM - SECTION THREE

- Read the payment options to the victim and make sure that the victim understands their options.
  - NOTE: Please see the "Supplemental Information" document for translations in seven (7) additional languages.
- Have the victim or legal guardian initial one selection of Option #1, #2 or #3.
- Have the victim or legal guardian print their name, sign and date the form.
  - NOTE: A minor may sign their own claim form so long as it is reasonable to conclude that they understand both the form and the payment options.
  - NOTE: Claim forms must bear the original signature of the victim or their legal guardian. Unsigned claim forms or photocopied signatures will be rejected. Verbal authorizations cannot be accepted.
- The licensed health care provider who performed the forensic exam must print their name, sign and date the form.
  - NOTE: Claim forms must bear the original signature of the licensed health care provider. Unsigned claim forms or photocopied signatures will be rejected.
- The licensed health care provider must record their license number and profession on the form.
  - NOTE: Profession means the provider's professional designation; i.e., MD, DO, NP, PA, and RN.

If you have questions, call the NYS Office of Victim Services at (800) 247-8035 or (518) 457-8727, or visit www.ovs.ny.gov