NEW YORK STATE OFFICE OF VICTIM SERVICES
MEDICAL PROVIDER FORENSIC RAPE EXAMINATION
DIRECT REIMBURSEMENT CLAIM FORM

INSTRUCTIONS: **This form is to be used when a healthcare provider is directly billing the New York State Office of Victim Services for reimbursement of costs associated with providing a forensic examination for a victim of rape or sexual assault.**

(1) Fill in all blanks on this form.
(2) Attach: Itemized bill including Physicians Procedural Terminology (CPT) Codes.

All Sections ONE through THREE must be completed.

(3) Mail the completed form and all attachments to:
New York State 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_____

Address_____ City_____ State_____ Zip_____

Date of Birth_____ Social Security Number_____

Was a Sexual Offense Evidence Collection Kit or Drug Facilitated Sexual Assault Kit used? ☐ Yes ☐ No

It is not necessary that the crime be reported to the police. If applicable and available, provide the following information:

Police Department_____ Complaint#_____

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

Billing Provider Federal I.D. Number 13-2655001 Date of Forensic Exam_____

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

Address 451 CLARKSON AVENUE City BROOKLYN State NY Zip 11203

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

The Billing Provider and the other service providers, by law, shall not bill the victim for these services. Payment made to the Provider by the New York State Office of Victim Services for the forensic rape examination and related services or other physical examination conducted for the purpose of gathering evidence as a direct result of the sexual offense shall be considered by Providers as payment in full.

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

- The law requires that the victim be advised orally and in writing that he or she 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 choose not to use my private insurance benefits but request that the NYS Office of Victim Services 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.
- I have been advised that I will have to use my private insurance if I file a claim with the Office of Victim Services for other medical services outside of the forensic exam.

Victim/Guardian Name (Print or Type):_____

Victim/Guardian Signature:_____ Date_____

Forensic Examiner Name (Print or Type):_____ License #:_____

Forensic Examiner Signature:_____ Date_____

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