

**DEPARTMENT OF JUSTICE
OFFICE OF VICTIM SERVICES
Forensic Rape Examination Payment Program
Claim Form**

INSTRUCTIONS: Use this form when a medical provider is billing the Department of Justice, Office of Victim Services, for reimbursement of costs associated with providing a forensic rape examination.

(1) Fill in all blanks on this form

(2) Attach an itemized bill including
HCFA form with CPT codes and notes

(3) Mail the completed form and all attachments to:

**Office of Victim Services
Attn: FREPP
555 Fuller Avenue
Helena, MT 59601**

All Sections MUST be completed. PLEASE PRINT.

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

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

Victim's Name _____

Address _____

Date of Birth _____ Social Security Number _____

Date mailed to FREPP _____

Forensic Rape Examination Kit Number _____

SECTION TWO: PROVIDER INFORMATION (TO BE COMPLETED BY MEDICAL PROVIDER)

Federal I.D. Number _____ Date of Forensic Exam _____

Facility Provider Name _____ License # _____

Address _____

Billing Department Contact Person _____ Phone Number _____

The medical provider understands that the \$600 payment it receives from the Office of Victim Services constitutes payment in full for performance of the forensic rape examination and that the provider may not bill the victim for covered costs associated with the exam that exceed the allowable payment of \$600.

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

I have been advised of the options of payment for the forensic exam. I understand that I **may** use private insurance benefits, including Medicaid, Medicare, HMO or any other insurance program, for payment for the forensic exam. I choose not to use my private insurance benefits but request that the hospital submit directly to the Office of Victim Services for payment. However, I also understand that if I have sustained physical injuries that my insurance company or myself may be responsible for those charges.

Victim/Guardian Name (Print or Type) _____

Victim/Guardian Signature _____ Date _____

Medical Examiner Name (Print or Type) _____ License # _____

Medical Examiner Signature _____ Date _____

If you have questions, call the Department of Justice, Victim Services Program at (406) 444-3653.

OVS # 10 (6/05)