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
PO Box 201410
1712 9th Ave
Helena, MT 59620-1410

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, 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)