

STEP 16A

Hospital Label

STATE OF NEW HAMPSHIRE VICTIMS' COMPENSATION FORENSIC SEXUAL ASSAULT EXAMINATION BILLING FORM

_____ (name of patient or "anonymous") has been informed that the NH Victims' Compensation Program can provide payment for the examination, collection of evidence, and treatment related to this sexual assault visit; including HIV Post Exposure Prophylaxis, if necessary. It is the intent of this form to allow the patient to make an informed decision concerning the method of payment she/he chooses.

Please choose an option:

- _____ Patient does not have insurance that would cover this treatment.
- _____ Patient does have insurance or Medicaid which will be billed. Patient will not be charged for any co-payments or deductibles associated with this treatment.
- _____ Patient does have insurance that would cover this treatment but does not want insurance carrier billed.

This section must be completed by the SANE provider or treating physician:

Forensic Sexual Assault Examination Kit # _____ **Patient's Account #** _____

Patient's Date of Birth (REQUIRED) _____ **RX (for HIV nPEP medications ONLY):** _____

Were HIV nPEP medications dispensed in ED? **Yes No** # of days HIV nPEP medications dispensed: _____
(circle one)

The City/State/County where assault occurred: _____

(NH Victims' Compensation Program can only provide payment for assaults occurring in NH. If assault occurred in another state, please contact the Victims' Compensation Program of that state.)

**HIV POST EXPOSURE PROPHYLAXIS PRESCRIPTION MEDICATIONS WILL BE PAID TO THE HOSPITAL/FACILITY AT
MEDICAID RATE BY THE NH VICTIMS' COMPENSATION PROGRAM.**

SANE or Attending Physician (please print) Signature of SANE or Attending Physician Telephone

Name of Facility Name of Billing Contact Person Telephone Date of Service

Please use the universal UB invoice with back up documentation, including the services provided, medical record and appropriate medical coding. This form must be attached to UB invoice. Failure to provide all requested information will result in denial of payment. When completed, please mail these documents to:

New Hampshire Victims' Compensation Program
Office of the Attorney General
33 Capitol Street
Concord, NH 033301
Telephone: 603-271-1284
victimcomp@doj.nh.gov

Note to provider: Be sure that your billing department has a copy of this completed Billing Form and Instructions.



STATE OF NEW HAMPSHIRE

Forensic Sexual Assault Examination Billing Form

INSTRUCTIONS

1. The patient has the right to remain anonymous or provide their name when submitting a forensic sexual assault exam. Please list anonymous OR the patient's name.
2. **Payment options:**
 - a. Option 1: If this option is selected the hospital will be reimbursed by the NH Victims' Compensation Program at the Fee for Service Medicaid rate for evidence collection.
 - b. Option 2: If this option is selected, the patient cannot be billed for co-payment or deductibles.
 - c. Option 3: If this option is chosen, neither the patient nor the insurance provider is billed. The hospital will be reimbursed by the NH Victims' Compensation Program at the Fee for Service Medicaid rate for evidence collection
3. A forensic sexual assault examination kit number and patient's date of birth must be provided in order for the NH Victims' Compensation Program to consider payment at the Fee for Service Medicaid rate.
4. An itemized billing statement (universal UB form), with appropriate medical codes, must be submitted with the billing form for payment consideration. **Please also provide a copy of the medical record for this date of service.** Failure to provide a billing statement, medical record and payment form will delay the processing of this claim.
5. Complete all other sections of this form as indicated. Incomplete forms will be returned to the hospital as unable to process.
6. Once completed, MAIL/FAX this form and required billing documentation to:

The New Hampshire Victims' Compensation Program

**33 Capitol Street
Concord, NH 03301
603-271-1284
victimcomp@doj.nh.gov**