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):__________________

# of days HIV nPEP medications dispensed:_________ Was 7 days HIV nPEP medications dispensed in ER? **Yes No**

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 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.

Revised: 10/2015

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 in this section.
2. **<u>Payment options:</u>**
   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. Failure to provide billing statement/payment form will result in payment denial of the claim.
5. Complete all other sections of this form as indicated. Incomplete forms are subject to payment denial.
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