Appendix B – FRE form

FRE-01

NEW YORK STATE CRIME VICTIMS BOARD
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 Crime Victims Board for reimbursement of costs associated with providing a forensic rape or sexual assault examination.**

(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 Crime Victims Board
Attn: FRE Processing
1 Columbia Circle, Suite 200
Albany, New York 12203

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_____

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_____ Date of Forensic Exam_____

Billing Provider Name _____Operator Certificate or Facility I.D.#_____

Address_____

Billing Department Contact Person_____ Phone Number (____)_____

The Provider, by law, shall not bill the victim for these services. Payment made to the Provider by the New York State Crime Victims Board for the forensic rape examination or other physical examination conducted for the purpose of gathering evidence as a direct result of the sexual offense shall be considered by Provider 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 Crime Victims Board 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 Crime Victims Board 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 Crime Victims Board at (800) 247-8035 or (518) 457-8727.

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FRE DIRECT REIMBURSEMENT INSTRUCTIONS:

PRINT LEGIBLY – ILLEGIBLE CLAIM FORMS WILL BE REJECTED. ALL BLANKS MUST BE FILLED IN - FIELDS LEFT BLANK WILL RESULT IN REJECTION OF THE CLAIM

SECTION ONE

- Fill in the date and location of crime including city, county and state. If the date of crime can not be determined, please provide an approximation. This can be a year, a season, or a range of dates. Do not leave the date field blank. Do not use "unknown" or "not applicable" in this blank. Claims without a date or approximation of the date of crime will be rejected.
- Print the victim's name including the first and last name; address where the victim currently resides including city, state and zip code; victim's date of birth including the month, day and year of birth and victim's Social Security Number (SSN).
  NOTE: If the victim is undocumented or is an infant without a SSN, mark the SSN field "UNDOCUMENTED" or "INFANT, NOT ISSUED." If the facility is otherwise unable, after diligent effort, to obtain a Social Security number from the victim, mark the SSN field "NOT AVAILABLE" or N/A. Do not leave this field blank.
- Indicate whether an evidence collection kit was used by checking box yes or no. Note: Even where a kit is used, itemized bill must include CPT codes and rates/costs for each procedure performed during sexual assault forensic exam.
- If the crime was reported to the police, print precinct/department and the complaint number, if known.

SECTION TWO

- Print the billing provider's federal tax identification number.
- Print the date that the forensic examination was performed including the month, day and year of the examination.
- Print the name of the billing provider. This may be the name of a hospital or other Article 28 health care facility, a clinic, a private physician's office, a child advocacy center, a rape crisis center, etc.
- Print the facility's operating certificate number or facility ID number. If these numbers are unknown, contact the hospital administrator. If the facility is not a hospital or other Article 28 facility and does not have an operator's certificate or facility identification number, mark this field with "NOT APPPLICABLE" or "N/A" and indicate the type of facility in which the examination was performed. e.g. *"N/A – Child Advocacy Center."* If the facility is affiliated with a hospital, you may use the hospital's operating certificate number or facility ID.
- Print the address of the billing provider. THIS IS THE ADDRESS TO WHICH THE PAYMENT WILL BE MAILED.
- Print the name and telephone number of the billing department representative.

SECTION THREE

- Read the payment options to the victim and make sure that the victim understands their options.
- Have the victim or guardian print their name on the form and then sign and date the form. A minor may sign their own claim form so long as it is reasonable to conclude that he or she understands both the form and the payment options. Claim forms must bear an original signature. Unsigned claim forms will be rejected.
- The licensed health care provider who performed the sexual assault forensic examination must record their license number on the form and must also sign and date the form. Claim forms must bear an original signature.
- An itemized bill for services MUST be attached to each claim form. The law provides that the Board's reimbursement rate is to be reviewed and adjusted annually. In order to do so, the Board requires cost data whether or not the facility actually charges for the services provided.
- The Board requires that the itemized bill contain a service charge associated with each CPT code listed on the bill. Make sure to use the most current code set. In addition, the sum total of all charges must appear on the bill even if the total exceeds the maximum reimbursement rate.
- The itemized bill must include a diagnostic code or description indicating that "sexual assault," or "sexual abuse" is the primary diagnosis.
- The itemized bill MUST include a CPT office visit, office consultation, ER, or other visit code that is defined as "comprehensive," "detailed" or "complex" ("simple" visit codes are not acceptable).
- In addition to the CPT visit code and diagnosis described above, every claim involving an adult victim, (18 years of age or older) must include at least one of the CPT codes for the labs, pharmaceuticals and other services listed on the Board's website at http://www.cvb.state.ny.us/FRE.htm, and the attendant rates or charges on the itemized bill.

NOTICE: CPT CODES ARE SUBJECT TO CHANGE. YOU MUST USE THE MOST CURRENT CODE SET IN ORDER FOR THE CLAIM TO BE TIMELY PROCESSED.

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