LOUISIANA CRIME VICTIMS REPARATIONS BOARD
FORENSIC MEDICAL EXAM REIMBURSEMENT GUIDELINES
FOR HEALTHCARE PROVIDERS

Office: (225) 342-7756 · Fax: (225) 342-1672 · Nationwide Toll-Free: (888) 6-VICTIM
P.O. Box 3133 · Baton Rouge, LA 70821-3133 · lcle.la.gov/programs/cvr

GENERAL GUIDELINES

- As a healthcare provider, you can submit a claim to our program to be reimbursed for a forensic medical exam performed on a patient who presented with a chief complaint of sexual assault or child sexual abuse. LA R.S. 40:1216.1 specifically outlines the healthcare procedures for a patient who presents for treatment.
- The healthcare facility where the forensic medical exam was conducted will be reimbursed $1,000.00. The healthcare professional who performed the forensic medical exam will be reimbursed $600.00. The reimbursement amounts will cover the healthcare services listed in LA R.S. 40:1216.1(6). These services include the forensic examiner and hospital or healthcare facility services and supplies directly related to the forensic exam, scope procedures directly related to the forensic exam, laboratory testing directly related to the forensic exam, and any medication provided during the forensic exam. You cannot bill the patient for any of these services.
- The reimbursement claim form and attestation form are the only two documents required for reimbursement unless health insurance payments and adjustments are applied. The reimbursement amounts are subject to change if health insurance payments and adjustments are applied. See Section 3 below for details regarding the procedures involving health insurance.
- Any other healthcare services rendered that are not involved in conducting a forensic medical exam must be billed to the patient. Our program cannot be listed as an insurance plan for other healthcare services nor can our program be directly billed for other healthcare services.
- If all information is submitted correctly, you will receive a payment within 90 days from the date the claim is received by our program.
- Please inform the patient that our program may be able to assist with any medical bills they receive that are a direct result of a violent crime.

REIMBURSEMENT CLAIM FORM – SECTION 1

- Do not use an alias for the patient's name. The patient's legal name must be used. If the patient has two surnames, include both surnames.
- If the patient chooses not to give their full mailing address, please provide us with at least the state in which the patient resides.
- The patient's date of birth is required.
- Was the patient incarcerated when the incident occurred? If yes, please contact the correctional facility for payment. The Crime Victims Reparations Board does not reimburse a claim for an incarcerated individual.
- The gender and race of the patient are used for statistical purposes and in no way affect the Crime Victims Reparations Board's decision on approving or denying a claim.

REIMBURSEMENT CLAIM FORM – SECTION 2

- Did the patient present for a medical evaluation with a chief complaint of sexual assault or child sexual abuse? If not, do not submit a claim to our program. The patient must be billed.
- Did the incident occur in the state of Louisiana? Our program can only reimburse a claim if the incident occurred in Louisiana, or if the patient is a resident of Louisiana and the incident occurred in another state that does not have a crime victims reparations program.
- You are required to provide the location of the incident. Do not use unknown or not available.
- If the exact incident date is not known, provide an approximation which can be a month/year or date range. Do not use unknown or not available.
- If the patient is a minor or vulnerable adult, mandatory reporting is required by law. If the incident was reported to law enforcement or another investigative agency, you are required to list the name of the agency. Do not use an acronym for the agency name.

REIMBURSEMENT CLAIM FORM – SECTION 3

- During the visit, was a forensic medical exam performed on the patient? If not, do not submit a claim to our program. The patient must be billed.
- You are required to fill in the name and credentials of the forensic medical examiner with the examiner's license number and the name of the facility where the exam was conducted. Credentials mean RN, SANE-A, APRN, MD, etc. Do not use an acronym for the facility name.
- Did the patient choose to file with their health insurance which may be either a private or public health insurance plan? The patient is not required to file with their health insurance when a forensic medical exam is conducted. However, if the patient chose to file with their health insurance, their health insurance must be billed first. Once the insurance payment is received, the reimbursement claim form, attestation form, itemized bill showing payment and remaining balance, and explanation of benefits can be submitted to our program for any non-covered healthcare services rendered in conducting a forensic medical exam. If the patient does not have health insurance or chose not to file with their health insurance, the reimbursement claim form and attestation form can be immediately sent to our program for reimbursement.
- Select the type of healthcare provider requesting reimbursement. The healthcare facility is the hospital or clinic where the forensic medical exam was conducted. The healthcare professional is who performed the forensic medical exam (e.g., Registered Nurse, Nurse Practitioner, etc.).
- You are required to fill in the payee information and your information as the billing representative. You must sign and date the form.

ATTESTATION FORM

- The attestation form must be included with the reimbursement claim form and completed and signed by the forensic medical examiner.
- If you are a healthcare professional not directly associated with the healthcare facility where the forensic medical exam was conducted, you must leave a photocopy or exact reproduction of the completed and signed attestation form with the healthcare facility. The healthcare facility must submit the completed attestation form with their reimbursement claim form.

Mail all completed and signed forms to the:
Louisiana Crime Victims Reparations Board Office
P.O. Box 3133
Baton Rouge, LA 70821-3133

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SECTION 1 – PATIENT INFORMATION

First Name ______ Middle Initial ______ Last Name ______ Suffix ______

Address ______ City ______ State ______ Zip Code ______

Date of Birth ______ Social Security # ______

Did the incident occur while the patient was incarcerated? ☐ Yes ☐ No **If yes, please contact the correctional facility for payment.**

The information listed below is voluntary and will be used for statistical purposes only.

Gender		Race		
☐ Male ☐ Female	☐ Other ☐ Declined	☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander	☐ Black/African American ☐ Hispanic/Latino ☐ White Non-Latino/Caucasian	☐ Multiple Races ☐ Other ☐ Declined

SECTION 2 – INCIDENT INFORMATION

Did the patient present for a medical evaluation with a chief complaint of sexual assault or child sexual abuse? ☐ Yes ☐ No

If you answered no to the above question, do not submit a claim to our program. The patient must be billed.

Did the incident occur in Louisiana? ☐ Yes ☐ No Date of Incident ______ Date Reported ______

Location of Incident City ______ Parish ______ State ______

Was the incident reported to law enforcement or another investigative agency? ☐ Yes ☐ No

Name of Agency ______ Report # (if known) ______

If the patient is a minor or vulnerable adult, mandatory reporting is required by law. If the incident was reported to law enforcement or another investigative agency, you are required to list the name of the agency.

SECTION 3 – HEALTHCARE PROVIDER INFORMATION

During the visit, was a forensic medical exam performed on the patient? ☐ Yes ☐ No Date of Exam ______

If you answered no to the above question, do not submit a claim to our program. The patient must be billed.

Name and Credentials of Examiner ______ License # ______

Facility Where Exam Was Conducted ______

Did the patient choose to file with their health insurance issuer which may be either a private or public health insurance plan? ☐ Yes ☐ No

If the patient has no health insurance or chose not to file with their health insurance, this form and the attestation form can be submitted to our program for reimbursement for a forensic medical exam. If the patient chose to file with their health insurance, their health insurance must be billed first. Once the insurance payment is received, the reimbursement claim form, attestation form, itemized bill showing payment and remaining balance, and explanation of benefits can be submitted to our program for any non-covered healthcare services rendered in conducting a forensic medical exam.

Select the Type of Healthcare Provider Requesting Reimbursement ☐ Healthcare Facility ☐ Healthcare Professional

Payee Information

Remit To ______

Address ______ City ______ State ______ Zip Code ______

Account # or Invoice # ______ Date of Service ______ FEIN ______

Billing Representative Information

Name ______ Job Title ______

Email ______ Phone ______ Fax ______

On behalf of the healthcare provider, I authorize the Crime Victims Reparations Board to review this completed form in accordance with all applicable laws. I agree and certify that no person shall incur any legal liability to me by releasing any information pursuant to this authorization. A photocopy or exact reproduction of this signed release shall have the same force and effect as the original. I hereby certify, subject to the penalty of fine and/or imprisonment, that all the information submitted with this form is true and correct to the best of my knowledge and the expenses and/or losses to be claimed are for the healthcare services rendered in conducting a forensic medical exam.

______ ______
Signature of Billing Representative for Healthcare Provider Date

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This attestation form must be completed and signed by the forensic medical examiner who performed a forensic medical exam on a patient who presented with a chief complaint of sexual assault or child sexual abuse. When filing a claim with our program, this form must be submitted with a completed and signed reimbursement claim form. If you are a healthcare professional not directly associated with the healthcare facility where the forensic medical exam was conducted, you must leave a photocopy or exact reproduction of this completed and signed form with the healthcare facility. The healthcare facility must submit this completed form with their reimbursement claim form. The patient's full legal name must be provided. Please avoid using acronyms for the facility and agency fields. Please avoid using the term unknown for any information you provide on this form.

Patient's Name ______________________________

Date of Birth ______________ Social Security # ______________

Date of Incident ______________ Date of Exam ______________

Location of Incident (City/Parish and State) ______________________________

Facility Where Exam Was Conducted ______________________________

Agency the Incident Was Reported To ______________________________

I hereby attest that I am the healthcare professional who performed a forensic medical exam, as defined in LA R.S. 15:622, on the above-named patient. I also attest, subject to the penalty of fine and/or imprisonment, that all the information provided on this form is true and correct to the best of my knowledge.

______________________________ ______________

Printed Name and Credentials of Forensic Medical Examiner License Number

______________________________ ______________

Signature of Forensic Medical Examiner Date

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SANE Program or Healthcare Provider You are Representing