# SEXUAL BATTERY FORENSIC EXAMINATION CLAIM FORM

**INSTRUCTIONS:** To qualify for payment of medical expenses associated with the collection of forensic evidence following a sexual battery as defined by s. 794.011(1)(h), Fla. Stat., or lewd or lascivious battery or molestation as defined by s. 800.04(4) or (5), Fla. Stat., the medical provider must submit a claim form with accompanying itemized bill to the Office of the Attorney General, Bureau of Victim Compensation, PL-01, The Capitol, Tallahassee, FL 32399-1050, transmitted by facsimile to (850) 414-6197 or (850) 414-5779, emailed to VCIntake@MyFloridaLegal.com, or submitted via the department's web portal at https://VANext.MyFloridaLegal.com. The claim form and invoice must be received by the department within 120 days immediately following the initial forensic physical examination. Failure to submit a properly completed claim form and invoice will result in denial of benefits.

## SECTION ONE: VICTIM AND CRIME INFORMATION

To be completed by the forensic examiner based on information provided by the victim. *DATE OF BIRTH, RACE, GENDER, AND NATIONAL ORIGIN ARE COLLECTED FOR FEDERAL REPORTING PURPOSES AND ARE OPTIONAL.* (please print)

| 1. Victim's Name (last, middle, first): | 2. Date of Birth: |
|---|---|

3. Race (self-identified, check one): ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Multiple ☐ Hispanic/Latino ☐ Native Hawaiian or Other Pacific Islander ☐ White Non-Latino/Caucasian ☐ Other (please specify) _____

| 4. Gender (self-identified, check one): ☐ Female ☐ Male | 5. National Origin (please specify): |
|---|---|

| 6. Date Crime Occurred: | 7. City Where Crime Occurred: | 8. County Where Crime Occurred: | 9. State Where Crime Occurred: FL |
|---|---|---|---|

| 10. Did the crime occur while the victim was incarcerated or in custody? ☐ Yes ☐ No | 11. Has the victim contacted law enforcement? ☐ Yes ☐ No *(If no, skip to section two.)* | 12. Law Enforcement Agency Reported To: | 13. Case/Crime Report Number: |
|---|---|---|---|

## SECTION TWO: FORENSIC FACILITY INFORMATION

To be completed by the forensic examiner to identify information about the facility where the examination was performed. (please print)

| 14. Name of Facility Where Exam Was Completed: | 15. Facility Federal Tax Identification Number: | 16. Facility's Telephone Number: |
|---|---|---|

| 17. Facility Mailing Address: | 18. City: | 19. State: FL | 20. Zip Code: |
|---|---|---|---|

## SECTION THREE: EXAMINER INFORMATION

To be completed by the forensic examiner qualified to perform the initial forensic physical examination. (please print)

| 21. Date Initial Forensic Physical Examination Completed: | 22. Name of Forensic Examiner: | 23. Examiner's Title: | 24. State of Florida Medical License Number: |
|---|---|---|---|

**BY SIGNING, I AFFIRM AND THEREBY CERTIFY THAT ON THE DATE SPECIFIED ABOVE, THE INITIAL FORENSIC PHYSICAL EXAMINATION FOR WHICH THIS CLAIM IS BASED WAS PERFORMED FOR THE PURPOSE OF COLLECTING FORENSIC EVIDENCE FROM THE VICTIM IDENTIFIED IN SECTION ONE, USING PRACTICES CONSISTENT WITH THE ESTABLISHED ADULT AND CHILD SEXUAL ASSAULT PROTOCOLS.**

25. Examiner's Signature: _____ 26. Date: _____

## SECTION FOUR: MEDICAL PROVIDER INFORMATION

To be completed by a billing representative of the medical provider seeking reimbursement. (please print)

☐ Check box if the forensic facility in section two is the same as the medical provider seeking reimbursement and skip to number 34 below.

| 27. Name of Medical Provider: | 28. Medical Provider's Federal Tax Identification Number: | 29. Medical Provider's Telephone Number: |
|---|---|---|

| 30. Medical Provider's Payment Remittance Address: | 31. City: | 32. State: FL | 33. Zip Code: |
|---|---|---|---|

| 34. Medical Provider's Email Address: | 35. Name of Medical Provider's Billing Representative: | 36. Billing Representative's Title: |
|---|---|---|

37. As the medical provider's billing representative, have the medical records for the victim been reviewed to verify that the initial forensic physical examination was completed on the date and by the forensic examiner specified above (check one)? ☐ Yes ☐ No

**BY SIGNING, I ATTEST TO THE FACT THAT THE INITIAL FORENSIC PHYSICAL EXAMINATION WAS PERFORMED ON THE VICTIM IDENTIFIED IN SECTION ONE, AT THE FACILITY LOCATION IDENTIFIED IN SECTION TWO, BY THE FORENSIC EXAMINER IDENTIFIED IN SECTION THREE, AND PAYMENT FOR SERVICES IS OUTSTANDING TO THE MEDICAL PROVIDER HEREIN.**

38. Billing Representative's Signature: _____ 39. Date: _____

*To be considered for payment, this claim form must be accompanied by an itemized invoice prepared using industry standard forms or on the provider's letterhead. The invoice must include the facility name, address, and tax identification number; the date of the examination, the victim's name; diagnostic codes for the encounter for examination and observation following alleged adult or child rape; child sexual abuse suspected/confirmed; adult sexual abuse suspected/confirmed; and one or more of the following procedure codes: Certified or board-eligible healthcare examiner's office or other outpatient services; Emergency department services; Use of medical facility for the collection of forensic physical evidence; Venipuncture for the collection of blood samples; Laboratory tests for baseline sexually transmitted disease and pregnancy; or Forensic evidence collection kit. Only medical expenses connected with the initial forensic physical examination shall be considered. Payment is not contingent on health or disability insurance, participation in the criminal justice system, or cooperation with law enforcement officials. Chapter 960.28, Fla. Stat., provides that "Payment made to the medical provider by the department shall be considered by the provider as payment in full for the initial forensic physical examination associated with the collection of evidence. The victim may not be required to pay, directly or indirectly, the cost of an initial forensic physical examination performed in accordance with this section."*