VERMONT
CENTER FOR CRIME VICTIM SERVICES

PATIENT STAMP

SEXUAL ASSAULT BILLING FORM FOR CRIMES THAT OCCUR IN VERMONT

If you are a victim of a sexual assault, the Sexual Assault Program of the Vermont Center for Crime Victim Services can provide you with resources for payment of out of pocket medical expenses after your insurance is billed. We can help with the following: 1) Initial sexual assault examination, 2) Follow up medical care visits, 3) Up to (20) mental health counseling visits. If you would like financial assistance with mental health counseling or follow up care, please contact the Sexual Assault Program **BY CALLING (802)-241-1250 Extension 104**.

STEP 1: TO BE COMPLETED BY PATIENT- Authorization to Disclose Information

Because I am seeking treatment for a sexual assault that occurred in Vermont, I ______________________ authorize my health insurer to release eligibility information, policy type, and information specific to claims and services related to my sexual assault treatment to Vermont Center for Crime Victim Services, 58 Main St. Suite 1, Waterbury, VT 05676-1599. I authorize the medical facility responsible for my crime-related treatment to release billing information, diagnosis codes, and the corresponding explanation of benefits to Vermont Center for Crime Victim Services. This authorization will remain in effect until I request revocation by sending written notification to my insurance company or the treating medical facility by clearly stating my revocation request and the date such revocation is to take effect.

Patient Signature **(required)**______________________________ Date **(required)**______________________

My safe contact information is below:

Mailing Address ____

Phone ______________________________ Email ____

Best day(s) and time(s) to contact me____

STEP 2: TO BE COMPLETED BY THE SANE-Sexual Assault Nurse Examiner (required)

Did the assault occur in Vermont? ☐ YES ☐ NO If **NO**, what state did the assault occur in? __________________

Date of Visit __________________ **Date of Assault**_________________ **Treating Facility** _______________________

SANE NAME _______________________________________ **SANE /Facility phone**____________________________

Does this patient have medical insurance? YES ☐ NO ☐

If **YES,** Check one: ☐ VT-Medicaid ☐ BCBS-VT ☐ MVP ☐ Cigna ☐ Out-of-State Insurance ☐ Unknown

Insurance ID Number____________________ **Name of out-of-state insurance** _______________________________

Was a safety risk/privacy concern identified? Will it pose a safety risk or privacy concern for the patient if personal health information from the health insurer is sent to the address of the primary subscriber? ☐ YES ☐ NO

- If **YES** and the patient has BCBS-VT, MVP or Cigna, patient completes the PHI-Request for Confidential Communications of Protected Health Information.
- If **YES,** and the patient has out-of-state, no insurance, or VT-Medicaid, do not complete a PHI.
- If **NO**, do not complete a PHI-Request for Confidential Communications of Protected Health Information.
- **Did patient complete a PHI-Request for Confidential Communications?** ☐ YES ☐ NO

STEP 3: SANE, PLEASE VERIFY THIS FORM WAS PROVIDED TO THE FOLLOWING:

☐ This form was faxed to VERMONT CENTER FOR CRIME VICTIM SERVICES Fax 802-241-1253
☐ This form was sent to my FACILITY'S PATIENT BILLING DEPARTMENT
☐ A copy of BOTH sides of this form was given to the PATIENT
☐ A copy was attached to the patient's medical record

Sexual Assault Program Coordinator, 58 South Main St., Suite 1, Waterbury, VT 05675-1599
Phone (802)-241-1250 x104 Fax (802)-241-1253

 PLEASE SEE COMPLETE INSTRUCTIONS ON REVERSE

VERMONT
CENTER FOR CRIME VICTIM SERVICES

INSTRUCTIONS: SEXUAL ASSAULT BILLING FORM FOR CRIMES THAT OCCUR IN VERMONT

The medical provider is responsible for ensuring correct billing. This form may be used for a sexual assault that occurred in Vermont. For assaults that do **not** occur in Vermont, please consult that state for services available and proper kit protocol. You may contact the Sexual Assault Program for guidance **BY CALLING (802)-241-1250 Extension 104.**

STEP 1: TO BE COMPLETED BY THE PATIENT- Authorization to Disclose Information (Patient Instructions)

1. If you were assaulted in Vermont, the Sexual Assault Program can provide resources for payment of out-of-pocket medical expenses after your insurance is billed. We can help you with the initial sexual assault exam including collection of evidence, STI/HIV screening and prophylaxis, pregnancy testing, treatment of related injuries, follow-up medical care visits related to the sexual assault and up to twenty (20) mental health counseling visits per *8 V.S.A. § 4089 (2)(B).*
2. This signed and dated sexual assault billing form is required for the Sexual Assault Program to pay your medical bills. It also acts as a release allowing us to speak to your health insurer and the treating medical facility about your bill.
3. The Sexual Assault Program rarely needs to contact you. Although not required, it is helpful if you provide safe contact information and the best time to contact you.

STEP 2: TO BE COMPLETED BY THE SANE (SANE Instructions)

4. **Uninsured WITH or WITHOUT safety risk/privacy concern:** Check YES or NO for safety concern identified. It is NOT necessary to complete *Request for Confidential Communications of PHI.* All expenses related to this initial visit will be covered by the Sexual Assault Program. If the patient receives any bill, they should contact the Sexual Assault Program.
5. **Insured by BCBS-VT, MVP, Cigna or Medicaid WITHOUT a safety risk/privacy concern:** Check NO for safety risk/privacy concern identified. It is NOT necessary to complete *Request for Confidential Communications of PHI.* All expenses related to this initial visit will be covered by their health insurer or the Sexual Assault Program. If the patient receives any bill, they should contact the Sexual Assault Program.
6. **Insured by BCBS-VT, MVP, Cigna WITH a safety risk/privacy concern:** Check YES for safety risk/privacy concern identified. Complete *Request for Confidential Communications of PHI* with the patient. By completing the PHI, the patient has elected to divert insurance communications(mail) related to their care to another address. All expenses related to this initial visit will be covered by their health insurer or the Sexual Assault Program. If the patient receives any bill, they should contact the Sexual Assault Program.
7. **Insured by VT-Medicaid WITH a safety risk/privacy concern:** Check YES for safety risk/privacy concern identified, however It is NOT necessary to complete *Request for Confidential Communications of PHI* since VT-Medicaid will not mail communications related to their visit. All expenses related to this initial visit will be covered by VT-Medicaid. The patient should not receive a bill. If the patient receives any bill, they should contact the Sexual Assault Program.
8. **Insured by Out-of-State Insurer WITHOUT a safety risk/privacy concern:** Check NO for safety risk/privacy concern identified. It is NOT necessary to complete *Request for Confidential Communications of PHI.* All expenses related to this initial visit will be covered by their insurer or the Sexual Assault Program. If the patient receives any bill, they should contact the Sexual Assault Program.
9. **Insured by Out-of-State Insurer WITH a safety risk/privacy concern:** Check YES for safety risk/privacy concern identified, however it is NOT necessary to complete *Request for Confidential Communications of PHI* since out-of-state health insurer will not be billed when there is a safety risk/privacy concern present. All expenses related to this initial visit will be covered by the Sexual Assault Program. If the patient receives any bill, they should contact the Sexual Assault Program.
10. **Insurance status is unknown or limited information is available WITH or WITHOUT a safety concern:** Check YES or NO for safety concern identified. A *PHI* will be obtained later, if warranted. Instruct the patient to follow up with the hospital to provide insurance information. Advise the patient that the Sexual Assault Program may contact them directly to request insurance information. All expenses related to this initial visit will be covered by their health insurer or the Sexual Assault Program. If the patient receives any bill, they should contact Sexual Assault Program.

STEP 3: SANE MUST VERIFY THIS FORM WAS PROVIDED TO THE FOLLOWING

1. SANE's must provide this form to the Vermont Center for Crime Victim Services, treating facility's patient billing department, the patient, and the patient's medical record.
2. Failure to provide this form to the above parties could cause the patient to be billed.