Michigan Department of Community Health

MDCH

Rick Snyder, Governor
James K. Haveman, Director

For Office Use Only

Claim Number _____
Cross Reference_____
Approved _____
Paid _____

SAFE RESPONSE CLAIM FORM
SEXUAL ASSAULT FORENSIC EXAMINATIONS

Name of Patient: _____ **Date of Service:** _____

Date of Birth: _____ **Social Security Number:** _____

Medical Record Number: _____

1. INSURANCE

PROVIDERS MUST UTILIZE THE PATIENT'S INSURANCE before applying to the SAFE Response program, **UNLESS** the patient is uninsured or feels that submitting a claim to the insurance carrier **would substantially interfere with his or her personal privacy or safety**. A patient's insurance could include a traditional insurance plan, an HMO, a PPO, or a federally or state funded insurance program such as Medicare or Medicaid.

☐ **a. Patient has insurance:**

READ TO PATIENT: "In order to bill your insurance, I must have your written permission. If you believe that billing your insurance will put your personal privacy or safety at risk, you do not have to give permission to bill your insurance company. If your insurance is billed, you do not have to pay any co-pays or deductibles."

☐ **BILL INSURANCE:** The health care provider read the above statement to me and I agreed to have my insurance carrier be billed for this exam. I understand that I do not have to pay a co-pay or deductable.

_____ _____
Signature of patient or personal representative of the patient Date

☐ **BILL SAFE RESPONSE:** The health care provider read the above statement to me and I believe that submitting a claim to my insurance will substantially interfere with my personal privacy or safety.

_____ _____
Signature of patient or personal representative of the patient Date

☐ **b. If insurance is unavailable, or full reimbursement cannot be obtained from the patient's insurance, SAFE Response will be billed for eligible exam costs not covered by insurance.**

2. RELEASE OF INFORMATION TO SAFE RESPONSE PROGRAM

READ TO PATIENT: "The SAFE Response Program is a state program that will pay for exam costs that are not covered by insurance, or if you believe that billing your insurance will put your personal privacy or safety at risk. The SAFE Response Program will only pay for this exam if I provide the information requested on this form. After this form is sent to SAFE Response, I may also have to provide other written records from this exam to show that the information on this form is correct. Information I give to the SAFE Response Program that identifies you will only be used to process this claim for payment."

☐ **Patient Release:** The health care provider read the above statement to me and I agree that the information it describes can be given to SAFE Response so SAFE Response can pay for the exam. I do not give my permission for my personally identifying information to be given to any other person or group for any purpose whatsoever.

_____ _____

Signature of patient or personal representative of the patient Date

3. EXAM: EXAMINING PHYSICIAN OR SANE NURSE CERTIFICATION

I CERTIFY that I have conducted a sexual assault medical forensic exam on the patient named above. The exam consisted of all of the four elements listed below and all four elements were medically indicated. **SAFE Response will only pay claims for exams that include all of the four elements listed below**. **PLEASE INITIAL EACH ELEMENT AND SIGN BELOW.**

_____ Collection of a medical history
_____ A general medical examination
_____ One or more of the following procedures: a detailed oral, anal, or genital examination
_____ Administration of a standardized sexual assault evidence kit approved by the Department of State Police, as provided in MCL 333.21527. SAFE Response can only pay for an exam if the evidence kit is approved by the Department of State Police.

Time elapsed between the sexual assault and the provision of the exam:
☐ **0-24 hours** ☐ **25-48 hours** ☐ **49-72 hours** ☐ **73-96 hours** ☐ **over 96 hrs** ☐ **unknown**

_____ _____

Name Physician or Nurse Conducting Exam (Printed) License Number

_____ _____

Signature Date

4. CONTACT INFORMATION

Hospital/Provider Name: _____**Fed. Tax I.D. #:**_____

Address: _____

Contact Person Name: _____**Ph**:_____

A copy of the itemized billing must be submitted with this claim form within one year of the examination to:

Crime Victim Services Commission, **SAFE Response**
Capitol View Building
201 Townsend Street
PO Box 30195
Lansing MI 48909
Phone: (517) 335-SAFE (7233)

AUTHORITY: PA 223 of 1976 as amended. COMPLETION: Is voluntary, but is required if SAFE Response is desired. The Department of Community Health is an equal opportunity employer, services, and programs provider.