For Office Use Only

Claim Number _____
Cross Reference_____
Approved _____
Paid _____

SAFE RESPONSE CLAIM FORM
SEXUAL **A**SSAULT **F**ORENSIC **E**XAMINATIONS

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

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

Medical Record Number: _____

Did offense occur while patient was confined in a correctional facility? Yes ☐ **No** ☐

1. INSURANCE

***ALL 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.

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

☐ **a. Patient has insurance:**

☐ **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. BILL SAFE RESPONSE:** I do not have insurance.

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

I certify that I have read the above statements to the victim.

_____ _____
Signature of the provider or representative completing SAFE form Date

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, you may also have to provide other written records from this exam to show that the information on this form is correct. Information you 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 DECLARE AND CERTIFY that I have conducted a sexual assault medical forensic exam on the patient. The exam consisted of ALL four elements listed below and all four elements are medically indicated. **SAFE Response will only pay claims for exams that include all of the four elements listed below**. ***PLEASE** initial each element, print, and sign your name, write your license number and date of signature.

_____ 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. AUDIT AND RECORDS AGREEMENT: SANE Nurse OR Hospital Medical Records Staff can sign:

BY SIGNING THIS FORM, I agree to maintain adequate records and files, including the records documenting this examination, and that may support the activities, expenditures, and reimbursements related to this program. I assure that the records and detailed documentation will be maintained for a period of not less than four (4) years from the date of submission of the reimbursement request. I also agree to permit upon reasonable notification and at reasonable times, access by authorized representatives of the Department, Federal Grantor Agency, and State Auditor General, to any records, files and documentation related to this examination, to the extent authorized by applicable state or federal law, rule or regulation.

_____ _____

Name (Print) Physician or Nurse Conducting Exam Name (Print) Hospital/Provider Medical Records Administrator

_____ _____

Signature of Physician or Nurse Conducting Exam Signature Hospital/Provider Medical Records Administrator

_____ _____

Date Date

5. CONTACT INFORMATION

Hospital/Provider Name: _____Fed. Tax I.D#.: _____

Address: _____

Contact Person Name: _____Ph:_____

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

Crime Victim Services Commission, SAFE Response
Grand Tower, Suite 1113
235 South Grand Avenue
PO Box 30037
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 Health is an equal opportunity employer, services, and programs provider.