



# Georgia Crime Victims Compensation Program

## Forensic Medical Examination Application for Payment

O.C.G.A. § 17-5-72 provides that a victim shall have the right to a forensic medical examination, regardless of whether the victim participates in the criminal justice system (or cooperates with law enforcement by pursuing prosecution of the crime). A victim is not required to pay, directly or indirectly, for the cost of a forensic medical examination. The cost of a forensic medical examination (not to exceed \$1,000 per victim, per victimization) shall be paid for by the Georgia Crime Victims Compensation Program (Eligibility applies to sexual assaults occurring in Georgia on or after July 1, 2011).

**INSTRUCTIONS TO PROVIDERS:** All applicable sections of the Application for Payment should be completed. The application must be received by the Georgia Crime Victims Compensation Program within 1 year of the crime to be eligible for payment. Please include an itemized bill, HCFA1500, UB92, or a UB04 claim form with this application and mail to:

Georgia Crime Victims Compensation Program  
104 Marietta Street NW, Suite 440  
Atlanta, GA 30303  
If you have questions, please call (404) 657-2222 or (800) 547-0060

### SECTION 1 – VICTIM INFORMATION: *This section must be completed by the provider*

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_  
Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  Male  Female  
Did the alleged offense occur while the victim was incarcerated or in custody?  Yes  No  
Date of Crime \_\_\_\_/\_\_\_\_/\_\_\_\_ Did the alleged offense occur in Georgia?  Yes  No

### SECTION 2 - REPORTING AGENCY: *This section must be completed only if reported to an investigative agency*

Date of Report \_\_\_\_/\_\_\_\_/\_\_\_\_ Report/Case # \_\_\_\_\_  
Agency Name \_\_\_\_\_ Telephone Number (\_\_\_\_) \_\_\_\_\_  
Location of Crime \_\_\_\_\_  
City State Zip Code County

### SECTION 3 – FACILITY INFORMATION: *This section provides information on the facility where services were provided*

Name of Facility \_\_\_\_\_ FEI No. \_\_\_\_\_  
Address \_\_\_\_\_  
City State Zip Code County  
Date of Forensic Examination \_\_\_\_/\_\_\_\_/\_\_\_\_ Telephone No. (\_\_\_\_) \_\_\_\_\_

### SECTION 4 – REMIT TO: *This section indicates who to send the payment to*

Name \_\_\_\_\_ SSN or FEI No. \_\_\_\_\_  
Address \_\_\_\_\_  
City State Zip Code County

### SECTION 5 - ACKNOWLEDGEMENT: *This section is completed by the medical provider who conducts the forensic examination*

I declare and affirm under the penalty of perjury that the statements made on this Application for Payment are true and correct. I confirm that the forensic examination on which this claim is based was performed at this facility for the sole purpose of collecting forensic evidence on the above named victim. I confirm that none of the items/services listed on the itemized bill/claim form were donated.

Name of Provider (typed or printed) \_\_\_\_\_  
Provider's title \_\_\_\_\_ SSN or FEI No. \_\_\_\_\_  
Provider's signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

### ***Application for Payment Policies and Procedures***

By signing this application for payment, you acknowledge that all of the information and the subsequent itemized bill(s) provided with this application, are subject to penalty of perjury pursuant to O.C.G.A. § 17-15-11, and the request for payment for the reasonable costs of a forensic medical examination complies with the following provisions:

1. The sexual assault occurred in Georgia on or after July 1, 2011; otherwise, the appropriate law enforcement agency must be billed.
2. The Georgia Crime Victims Compensation Program will pay for the cost of a forensic medical examination up to \$1,000 per victim, per victimization.
3. The Application for Payment and the HCFA-1500, UB04, UB92, or itemized statement/bill must be submitted within 1-year of the crime occurring. **Please Note:** The Georgia Crime Victims Compensation Program may request additional documentation at anytime for the purposes of making a final claim determination.
4. All applicable sections of the **Application for Payment** must be completed. Incomplete applications will not be processed and will be returned to the person that submitted the application, noting the reason the application is incomplete. The acknowledgement section of the application must be signed by the medical professional that conducted the forensic medical examination. **Please Note:** We must have an eligible application **with an original signature** on file before we can remit payment.
5. A physician, physician assistant, registered nurse, SANE-A (adult adolescent) or SANE-P (pediatric) must have performed the forensic medical examination.
6. All charges/services associated with the forensic medical examination that was performed must be itemized and submitted with the application, and only those expenses for the actual examination will be considered for payment. The bill **must** be submitted at one time, within **30 days** of the examination. Follow-up visits for additional sexually transmitted illnesses (STIs) testing may be submitted at a later time; however, the total for all expenses must not exceed \$1,000 per victimization.
7. The Forensic Medical Examination Fee Schedule reflects the maximum allowable cost for each service and/or procedure related to a forensic medical examination for sexual assault victims. Any services, procedures or medications not listed, but related to the forensic medical examination, should be submitted for review.
8. Payment made by the Georgia Crime Victims Compensation Program for a forensic medical examination must be considered as payment in full. The victim cannot be billed directly or indirectly for a forensic examination. All other services can be billed to the victim or their respective insurance.
9. The Georgia Crime Victims Compensation Program is not bound by any billing or contractual agreements made between agencies and/or service providers.
10. The provider and/or facility should bill the Georgia Crime Victims Compensation Program the usual and customary charges for the forensic examination on a HCFA-1500, UB04, UB92, or itemized statement. To be considered for reimbursement, the bill for service must include the associated CPT Code or Revenue Code and an itemization of the services provided.
11. The cost of only **two** forensic medical examinations per year, per sexual assault victim, will be considered a reasonable cost. If more than two requests are submitted per year, per victim, the **third** claim will be submitted to the Georgia Crime Victims Compensation Board for consideration.
12. Any provider and/or facility submitting their **Applications for Payment** are subject to a site visit by the Criminal Justice Coordinating Council and must cooperate with the site visit process as a condition of receiving future payments for forensic medical examinations.
13. The victim may apply to the Georgia Crime Victims Compensation Program to be considered for other eligible expenses (i.e., medical, mental health counseling, funeral, crime-scene clean-up or lost wages/loss of support). Please contact us at 404-657-2222/800-547-0060 or at [cjcc.ga.gov](http://cjcc.ga.gov) for an application to apply for the above benefits.

**Please Note:** For additional information, please refer to our website at [cjcc.ga.gov](http://cjcc.ga.gov)