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This PDF has been designed to help you navigate your way through our Payment and Reimbursement process. In preparation of this material, every effort has been made to offer the most current, correct, and clearly expressed information possible. However, this information is for general purposes only. While SOVA makes every effort to provide accurate and updated material for you; periodically, data may change prior to any updates and revisions. Therefore, you are encouraged to contact our office if you have any questions.

This material is not provided as a guarantee for payment or pre-approval for services. SOVA is providing this information in an effort to decrease the turn-a-round time for processing claims. All claims or applications for assistance must meet the eligibility criteria prior to consideration with crime related compensable expenses. Victims/claimants are encouraged to provide this agency with the appropriate documentation for reimbursement and payment consideration.

Forms:
Any information submitted on the forms is fictitious and intended for sample purposes only. Actual forms will reflect real data entered by providers. This material also includes forms from organizations other than SOVA and has been provided for sample purposes only.

Victim’s privacy:
To protect victim/claimant’s privacy, SOVA will not provide information to family or friends without prior authorization from the victims/claimants in writing.

Pre-existing conditions:
If you have a pre-existing medical/dental condition (a condition that existed prior to the crime), you could be required to provide the agency with a Certificate of Clinical/Dental Necessity from your treating physician/clinician/dentist certifying that your treatment is directly related to the crime on which the claim is based and that the expenses incurred as a result of your treatment are crime related.

Payer of Last Resort:
SOVA is an eligibility program. All submitted compensable expenses will be offset by other available sources before reimbursements/payments are considered. Victims will be required to file all compensable expenses with his/her private or public health insurance company/carrier first; this includes Medicaid and Medicare. Victims’ compensable expenses are also offset by restitution, subrogation or civil settlements. Because SOVA is not a guarantor for crime victims compensable expenses, providers are encouraged to mail all bills to victims and forward UBs/HCFAs etc. to SOVA.

Change of address for victims/claimants:
To ensure timely payments/reimbursements or to avoid interruptions of lost wages, the victims/claimants will be required to provide SOVA with change of address and telephone number.

Collection Activity:
Section 16 3 1360: Collection activities prohibited
When a person files a claim pursuant to this article, a health care provider that has received written notice of a pending claim is prohibited from all debt collection activities relating to medical and psychological treatment received by the person in connection with the claim until an award is made on the claim or the claim is determined to be non-compensable and is denied, or ninety days have passed after the health care provider first received notice of a pending claim.

$100.00 Threshold:
Section 16-3-1180(D) An award may be made only if and to the extent that the amount of compensable loss exceeds one hundred dollars; however, this limitation may be waived in the interest of justice and must be waived upon a showing that the claimant is at least sixty-five years old.

Claims inactive for more than 18 months:
Section 16-3-1180(E) A previously decided award may be reopened for the purpose of increasing the compensation previously awarded. The State Office of Victim Assistance shall send immediately to the claimant a copy of the notice changing the award. This review may not be made after eighteen months from the date of the last payment of compensation pursuant to an award under this article unless the director determines there is a need to reopen the case as specified in Section 16-3-1120(4).
PART ONE:

COMPENSATION PROGRAM

SOVA has a four (4) step payment process

Step 1
The Intake Process
You will receive a letter in the mail confirming that your application has been received.

Step 2
The Eligibility Process
If your claim is eligible, you will receive an eligibility letter. If your claim is denied, you will receive a denial packet.

Step 3
The Restitution Subrogation Process
If your claim meets the eligibility criteria, you will receive a letter regarding your responsibility when restitution is ordered by the court or if you receive a settlement from other insurance.

Step 4
The Payment & Reimbursement Process
Your crime related bills and expenses will be processed for payments to your providers and reimbursements to you.

For eligible claims: SOVA will begin to process your payment in step 4. To assist with Step 4, please review the Payment & Reimbursement At-a-Glace sheet.

You may begin to contact your Doctor, Dentist, Counselor, or the Hospital and request that a medical/dental claim form be faxed to the agency at (803) 734-2261. After you receive your Notice of Award letter, allow 4 to 6 weeks for payments.
Crime Related Expenses (For Medical/Dental/Eyeglasses)

Medical

Victims must submit the following forms for his/her crime related medical expenses to be considered for payments/reimbursements:

One of the following forms will be required for all separate crime related dates of service. The victim will have to contact his/her provider (provider can mail or fax the medical claim forms).

• UB-04 Medical Claim Form
• UB-92 Medical Claim Form
• Health Insurance Medical Claim Form (CMS-1500) (HCFA-1500)
• Itemized bill of Charges from your medical provider
• Health Insurance information Explanation of Benefits (EOB)

When the victim has health insurance coverage, he/she will be required to provide information.

• Explanation of Benefits from the Health Insurance Company or provider (EOB)
• Pursuant to public and private health insurance guidelines regarding timely filing and pre-authorization, victims are required to provide providers with health insurance information.

Dental

Victims must submit the following forms for his/her crime related dental expenses to be considered for payment/reimbursements: (Look for the Dental Fee Schedule in Section Three.)

One of the following forms will be required for all separate crime related dates of service. The victim will have to contact his/her provider (provider can mail or fax the dental claim forms).

• Itemized bill of Charges from your medical provider
• ADA Dental Claim Form (w/ treatment plan)
• Health Insurance information Explanation of Benefits (EOB)

When the victim has dental insurance coverage, he/she will be required to provide information.

• Explanation of Benefits from the Health Insurance Company or provider (EOB)
• Pursuant to public and private health insurance guidelines regarding timely filing and pre-authorization, victims are required to provide providers with health insurance information.

Eyeglasses

Replacement or purchase of eyeglasses is a compensable expense when:

• It is found that the victim’s glasses were broken or damaged during the incident;
• The damaged/broken glasses were reported to law enforcement;
• The information is in a police report or supplemental report;
• A detailed bill from your chosen vision center is submitted
• The injury was reported to law enforcement;
• The victim’s vision is impaired as a direct result of the crime;
• Medical documentation supports that the glasses are medically necessary;
• A detailed bill from your chosen vision center is submitted.

Note: SOVA will pay a maximum of $125.00 for eyeglass frames. Lenses are covered in full according to the prescription when it is found to be medically necessary. Warranties are not a covered expense.
Claimants must submit the following forms/documents for the crime related funeral expenses to be considered for payments/reimbursements:

- Death Certificate
- Itemized bill/contract (The bill must include the service provider’s name and remit address.)

The person who is responsible for the funeral expenses incurred may file for reimbursements relating to the cost of the funeral. The responsible party is the person(s) who signed the contract or who paid the funeral bill.

Compensable Medical Expenses:

- If the deceased victim was an adult, the victim’s spouse may file for any compensable medical expenses that he/she may have incurred.
- If the deceased victim was a minor child, the parent may file for any compensable medical expenses he/she may have incurred.

Crime Related Counseling Expenses

- SOVA’s mental health policy provides an incremental approach to outpatient mental health sessions’ limitation. This approach was implemented on July 1, 2012 and applies to all eligible and active claims.
- The Provider must be a licensed mental health professional, who has received specific training in evidence based treatment that have been shown to be effective in meeting the need of crime victims.

For consideration with approved limits, providers will be required to provide the following:

- SOVA Mental Health Counselor’s Report
- SOVA Additional counseling Sessions Request form for additional sessions
- Itemized bill of Charges or,
- Health Insurance Medical Claim Form (CMS/HCFA-1500)
- Explanation of Benefits (EOB) for each date of service

Payer of Last Resort:
The State Office of Victim Assistance is the payer of last resort. If the victim has insurance, and the victim elects not to use his/her insurance for treatment, SOVA will not cover the cost. It is the provider’s responsibility to ensure that other avenues of payments are explored and used.

Timely Filing:
SOVA highly recommends that claims be filed as soon as possible after services have been rendered to ensure prompt payments. However, SOVA requires providers to submit invoices and medical claim forms within 12 months from the date of service. Request for payment submitted after 12 months from the date of service will not be considered. For new victim compensation claims/applications: Claims (invoices/medical claim forms) for services provided must be submitted within 12 months after the date of eligibility.
Crime Related “Out of pocket expenses” for

**Prescription Drugs**

Victims must submit the following information for his/her crime related “out of pocket expenses” to be considered for reimbursement:

**One of the following will be required** (Some victims will have to provide additional information from his/her treating physician)

- Copy of receipt from the pharmacy (*receipt must have* - patient’s name, date, total charge, name of medication, RX (prescription) number, name of the pharmacy & name of the doctor), or
- Print out of ‘patient history’ from the pharmacy.

---

**Mileage for Transportation To and From Medical/Dental/Counseling Appointments**

Victims must submit the following information to be considered for reimbursement for his/her expenses relating to transportation to and from appointments:

**MILEAGE: What will be required?**

- A written request from the victim/claimant
- List of appointments for which you are requesting consideration for mileage
- Medical claim forms/itemized bills for each appointment

**IMPORTANT NOTE:** *(Mileage is considered for SOVA’s compensable related expenses ONLY)*

- Medical/Dental/Counseling claim forms are used to confirm appointments.
- The distance between the victim/claimant’s home and the medical/dental/counseling facility must be 5 miles or more (one way).
- The request must be submitted in writing (the request must include the date of the visit, service type and location)

**The following are non-covered expenses:**

- Mileage for court appearances
- Mileage for meetings with law enforcement
- Mileage for meetings with Solicitors
- Mileage for Medicaid and Medicare recipients
CRITERIA: (all four criteria must be met)
1) Employed: The victim must have been employed at the time of the crime;
2) Missed time from work: The victim must have missed two (2) consecutive weeks from work as a direct result of the crime;
3) Reportable income: Reimbursement is based on reportable income; and
4) Disabled: The victim must be under the care of a treating physician.

LOST WAGES: (The victim must have been employed at the time of the crime and missed two consecutive weeks from work as prescribed by the treating physician.)

Victims must submit the following information for his/her crime related lost wages to be considered for reimbursement:

• SOVA Employer’s Report
• SOVA Physician’s Disability Report
• Copy of your last two pay stubs prior to the incident
• Other documentation may be required for individuals who are self-employed (See the ‘Self Employed’ section for additional information)

Self-Employed

This section applies to you:

• If you were self-employed at the time of the crime
• If you received your earnings in cash, personal checks or money order
• If you received your earnings in tips
• If you report your income to the IRS

Victims must submit the following information for his/her crime related lost wages to be considered for reimbursement: To establish disability, employment and reportable income; three (3) supportive documentations will be required. The criteria for lost wages are listed under Crime Related Lost Wages.

1) Disability:
• SOVA Physician’s Disability Report will be required to establish disability and length of disability.

2) Employment:
• SOVA Self-Employment Verification of Lost Wages Form
• A copy of your Business License (if applicable), or
• Documentation showing you were receiving income, from the business, at the time of the crime

3) Reportable Income: (lost wage benefits are calculated using information for the year of the crime)
• Your Tax Return Transcript from the IRS is required (must submit the last two years prior to the crime)
NOTE: Payment for lost wage benefits are limited to one half of the overall compensation award amount and a 12-month disability period.

To have your tax return transcript mailed to you:

You can order your tax return transcript(s) using the IRS Order a Transcript self-service transcript order line at:

1.800.908.9946: Then,
Select option 1 for English, then
Enter your SS#, then
Select 1 to confirm your SS#, then
Enter your house or apartment number,
You will be provided with instructions, then
Select option 2 to order your transcript, then
Enter the year for the tax return you are ordering (year of the crime) i.e. 2013; 2012; 2011, then
Select option 1 to confirm the year for the tax return that you are ordering,
After the prompt, if your information is correct, select option 1, finally
Select option 3 to complete your order

There are no fees for the tax return transcript. You can expect to receive your transcript within 5 to 10 days from your order date.

To have your tax return transcript faxed to you:

You can order a faxed copy of your tax return transcript(s) by calling the IRS at 1-800-829-1040. **You must be near a fax machine at the time of the call.** Instructions are below:

1.800.829.1040 - IRS general information line
Select option 1 for English
Press zero or (wait to go through the prompts to speak with an operator)
Ask the operator to transfer you to the Advance Accounts Department. (The hold time is typically 15 minutes)
When the representative from the Advance Accounts Dept. comes on the line, you may request a faxed copy of your tax transcript. Be prepared to provide your social security number and a fax number.

There are no fees for the tax return transcript. You can expect to receive your transcript within 5 to 10 days from your order date.
Eligibility Criteria

SAP/CAP PROGRAM: Pursuant to SECTION 16-3-1350, SOVA is the primary payer and victims/claimants are not to be billed

- A crime occurred in South Carolina
- Claim must be filed within 180 days from the date of service

Sexual Assault (Acute) Protocols: (Victims 18 and older)

- SLED approved protocol must be followed

Anonymous Reporting: Sexual Assault (Acute) Protocols (Victims 18 and older)
SLED approved protocol must be followed: when providing law enforcement information – write in “Anonymous” instead of the name of the law enforcement agency: To establish that the crime happened in SC or incident jurisdiction, provide the county and state.

Sexual Assault (Chronic) Protocols: (Victims 17 and younger or vulnerable adults)

- South Carolina Children’s Advocacy Medical Response System Child Maltreatment Protocol must be followed …… visit http://www.sccamrs.org for more information
- The crime was reported to law enforcement

Forensic Interviews: (Victims 17 and younger or vulnerable adults)

- The forensic interview was performed using the standards defined by SOVA
- The crime was reported to law enforcement

PAYMENT STIPULATION: For reimbursement of Sexual Assault or Physical Abuse (Chronic) Protocols and Forensic exams or Forensic interviews, a law enforcement agency is required to be the initiating/requesting party. SOVA will only pay for allowable charges incurred, in gathering evidence from a victim 17 and under or a vulnerable adult, when done at the request of law enforcement.
Billing Fact Sheet

Sexual Assault Forensic Medical Examination – 18 and older

Pursuant to SC Code Section 16-3-1350, which follows the guidance of the federal Violence Against Women Act statute, victims of assault in the State of South Carolina may request, at no cost to them, a forensic examination for sexual assault, regardless of their involvement with law enforcement. Health Care Providers will bill SOVA directly for individual charges for lab work, emergency room fee, physician’s fee, etc. Neither the victim nor their insurance, including Medicaid and Medicare, may be billed for the medicolegal examination. Any fees beyond the actual collection of any evidence during a forensic examination will be the responsibility of the victim. Should law enforcement be involved, the option of SOVA victim compensation reimbursement becomes available.

Payment for a routine medicolegal examination of any alleged victim of assault in any degree is dependent upon the following criteria/conditions:

- The assault must have occurred in South Carolina
- SLED approved Sexual Assault Protocol must be followed
- SOVA Sexual Assault Protocol (SAP) Billing Statement must be submitted
- SOVA Medical Examination Release Form must be submitted: NOTE: For Anonymous Reporting: when providing law enforcement information, write in ‘ANONYMOUS’ instead of the name of law enforcement agency. To establish that the crime/incident occurred in SC, the incident location (county and state) will be required.

The medical examination release form and the SOVA billing statement found in the evidence collection kit must be completed and submitted to the State Office of Victim Assistance providing the following:

- Name, address and signature of victim
- Name and address of the health care facility
- When the incident was reported to law enforcement, the agency’s name is required
- Incident location (county and state)

No payment will be made unless forms are completed and submitted with correct documentation within 180 days from the date of the exam.

This Program is not permitted to pay for additional procedures such as:

- Surgery, hospital admission, follow-up counseling, x-rays, follow-up examinations, treatment, blood work, alcohol or drug screens, or testing, stat charges, etc.
  [Victims of assault who incur charges not covered under the Sexual Assault Protocol Program may submit a Victim Compensation application for payment consideration to the Victims’ Compensation Fund.]

The Protocol Program makes payments to health care providers on a monthly basis. When multiple claims are submitted from a single provider for payment, one check is issued and sent with a list showing victims covered by the payment.

If you need additional information you may contact us by calling 803.734.1900.
Forensic Interviews

The State Office of Victim Assistance (SOVA) is authorized by state law (SC CODE SEC 16-3-1350) to pay for allowable charges incurred in gathering evidence from a victim at law enforcement's request. The forensic interviewer must be a master's level licensed mental health professional and have participated in at least one forty-hour specialized forensic interviewer training provided through the American Prosecutor's Research Institute (APRI) Finding Words, the National Children's Advocacy Center (NCAC), or the American Professional Society on the Abuse of Children (APSAC). If not licensed, the forensic interviewer must be supervised by a licensed mental health professional, i.e. LMSW, LISW, LMFT, or LPC. Anyone supervising an unlicensed interviewer must provide a copy of their license. The unlicensed interviewer must be working towards a license. Once licensed the interviewer must provide a copy of their license.

To receive reimbursement for performing a forensic interview, the interviews must be conducted at a facility that follows the multi-disciplinary model; a billing invoice for services rendered as well as a summary of the findings must be submitted and signed by the service provider. Providers must have previously been approved by SOVA. Victims or their insurance must not be billed for these services.

In addition, a release form must be completed and submitted along with the billing invoice and summary of findings. This release must include:

1. Victim’s name, address and signature of the victim/guardian,
2. Name, credentials and signature of the forensic interviewer,
3. Name and address of the provider,
4. Location of crime and name of the law enforcement agency that took the report,
5. Name of the investigating/reporting officer (and signature, if available).

Payment for a forensic interview of a child alleged to be the victim of physical or sexual assault is contingent upon the following conditions:

1. The crime must have occurred in South Carolina.
2. The victim or guardian must file an incident report with law enforcement.
3. The forensic interview must be ordered by law enforcement.
4. The forensic interview must be performed using the standards defined by SOVA.

A law enforcement incident report that names each child as a victim is required along with the billing information.

The program cannot pay for additional procedures such as psychological testing/evaluation or mental health treatment. Victims who incur other crime related medical or mental health bills may submit a separate Crime Victim’s Compensation application to SOVA. The application will be reviewed for eligibility for certain benefits including mental health counseling. Also, a victim must file with his or her health insurance first for other incurred expenses. SOVA will consider balances due for treatment after payment by individual insurance.
PART THREE:
PAYMENTS & REIMBURSEMENTS
“At a Glance”

Who may file a “Crime Victim’s Compensation Application” with SOVA?

The Direct Victim: The victim who sustained the injury or the victim who died as a direct result of the crime related injury sustained.

The Indirect Victim: Crime Type Specific

The Direct Victims’ Spouse: Consideration for Counseling Expenses
The Direct Victims’ Children: Consideration for Counseling Expenses
The Direct Victims’ Parents: Consideration for Counseling Expenses
The Direct Victims’ Siblings: Consideration for Counseling Expenses

An application must be submitted for each person filing for compensation.

A claim/application must be submitted for the direct victim first before consideration will be given to the indirect victim’s claim/application.

Benefits for the indirect victim (spouses, children, parents, and siblings) are contingent upon the eligibility status of the direct victim’s claim: If the direct victim’s claim is eligible, the indirect victim’s claim could be deemed eligible. If the direct victim’s claim is ineligible, the indirect victim’s claim could be deemed ineligible.
## Compensation Program: An Assistance Program Payer of Last Resort

**SECTION 16-3-1180 & 16-3-1360**

<table>
<thead>
<tr>
<th>Category</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical/Dental/Optical Expenses</td>
<td>*Must provide: UB04/UB92/CMS 1500 medical claim form/itemized bill or ADA dental claim form along with EOB for each date of service</td>
</tr>
<tr>
<td>Funeral Expenses</td>
<td>*$4,000 maximum allowed Taken from the total award</td>
</tr>
<tr>
<td>Counseling</td>
<td>*20 sessions/180 days *SOVA's mental health policy provides an incremental approach</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>*Must submit a copy of the paid bill from the pharmacy</td>
</tr>
<tr>
<td>Mileage</td>
<td>*Medical/Counseling/Dental Appointments only Compensable bills are used to confirm compensation</td>
</tr>
<tr>
<td>Lost Wages</td>
<td>*Must have missed 2 consecutive weeks from work as prescribed by the Treating Physician: NOTE: SOVA is the payer of last resort for Lost Wages</td>
</tr>
<tr>
<td><strong>Compensation Program</strong></td>
<td>All reimbursements are subtracted from the $15,000 maximum award amount.</td>
</tr>
</tbody>
</table>

## Sexual Assault Program: Evidence Collection

**SECTION 16-3-1350**

<table>
<thead>
<tr>
<th>Category</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual Assault Acute Protocol</td>
<td>*Evidence collected within 120 hours of the assault</td>
</tr>
<tr>
<td>Anonymous Reporting</td>
<td>Sexual Assault Acute Protocol *Evidence collected within 120 hours of the assault -for victims 18 and older</td>
</tr>
<tr>
<td>Sexual Assault Chronic Protocol</td>
<td>*Evidence collected after 72 hours of the assault (<a href="http://www.sccamrs.org">www.sccamrs.org</a>)</td>
</tr>
<tr>
<td>Forensic Interviews</td>
<td>*Interview ordered by Law Enforcement $175.00 one-time fee</td>
</tr>
<tr>
<td><strong>For all medical treatment as a result of physical injuries sustained during the assault, and for follow-up appointments, A victim compensation application will be required</strong></td>
<td></td>
</tr>
</tbody>
</table>
## Payment & Reimbursement At A Glance

<table>
<thead>
<tr>
<th>IF you are requesting assistance with:</th>
<th>THEN you will need to provide:</th>
</tr>
</thead>
</table>
| **Crime Related Medical/Dental/Optical Expenses** | UB-04 Medical Claim Form (from your provider)  
UB-92 Medical Claim Form (from your provider)  
Health Insurance Medical Claim form (CMS-1500) (HCFA-1500) (from your provider)  
Itemized bill of charges from medical provider  
ADA Dental Claim Form (w/treatment plan) (certificate of dental necessity might be required)  
Itemized bill from vision center for eyeglasses  
EOB (Explanation of Benefit from Health/Dental insurance company) (Health/Dental/Medicaid must be filed first if a victim has private or public insurance) When the victim has Health/Dental/Medicaid Insurance coverage, he/she will have to provide information for all crime related dates of service. |
| For payments to the providers or reimbursements to victims, one or more of the following will be required for all separate crime related dates of service.  
The State Office of Victim Assistance is the payer of last resort. If the victim has insurance, and the victim elects not to use his/her insurance for treatment, SOVA will not cover the cost. It is the provider’s responsibility to ensure that other avenues of payments are explored and used.  
**NOTE:** SOVA pays after health and dental insurance. | |
| **Crime Related Counseling Expenses** | SOVA Mental Health Counselor’s Report  
SOVA Additional Counseling Request Form  
Itemized Statement of Charges w/CPT codes, or  
Health Insurance Claim Form (CMS/HCFA-1500), (Providers can fax a copy to SOVA)  
Explanation of Benefit (EOB) from the health insurance company  
**NOTE:** Insurance must be filed first if a victim has private or public insurance. |
| SOVA provides reimbursement for trauma (generally considered as a medical expense) only when such service is rendered by a professional who is licensed in a specialty which includes mental health counseling; this includes LMSW (when not practicing independently) LPC, LMFT, LCSW, LISW, Psychiatrist, Psychologist, and MD.  
**NOTE:** SOVA’s mental health policy provides an incremental approach to outpatient mental health sessions.  
**NOTE:** The provider must have received specific training in evidence-based treatment that has been shown to be effective in meeting the needs of crime victims.  
**NOTE:** SOVA pays after health insurance. | |
| **Crime Related Expenses for Medication** | Copy of receipt from the pharmacy ("receipt must have" - patient’s name, date, total charge, name of medication, RX number, name of the pharmacy and name of the doctor) or  
Print out of ‘patient history’ from the pharmacy  
**NOTE:** SOVA pays after health insurance. |
| For reimbursements to victims, one or more of the following will be required: (Some victims will have to provide additional information from his/her treating physician if the medication appears to be for a pre-existing condition or non-crime related condition.) | |
| **Crime Related Funeral Expenses** | Death Certificate  
Itemized bill/contract (* bill must include service provider’s name and remit address) |
| The person who is responsible for the funeral expenses incurred may file for reimbursement relating to the cost of the funeral. That will be the person(s) who signed the contract or who paid the funeral bill. | |
### Crime Related Lost Wages

The following 4 (four) criteria must be met:

1. **Employment:** The victim must have been employed at the time of the crime,
2. **Missed time from work:** The victim must have missed two (2) consecutive weeks (14 days) from work as a direct result of the crime,
3. **Reportable income:** Reimbursement is based on reportable income, and
4. **Disabled:** The victim must be under the care of a treating physician.

#### Crime Related Lost Wages

(You were **self employed** at the time of the crime)

1. **Employment:** The victim must have been employed at the time of the crime,
2. **Missed time from work:** The victim must have missed two (2) consecutive weeks (14 days) from work as a direct result of the crime,
3. **Reportable income:** Reimbursement is based on reportable income, and
4. **Disabled:** The victim must be under the care of a treating Physician.

**NOTE:** Because SOVA is a payer of last resort, all sources such as annual or sick leave, long/short term disability, SSA/SSI must be exhausted before SOVA will consider lost wage benefits.

**NOTE:** Payment for lost wage benefits are limited to one half of the overall compensation award amount and a 12 month disability period.

### Important Information

**Unprocessable Forms**

The following are forms/documents that are **UNPROCESSABLE** and cannot be accepted.

- Final Notice
- Statements
- Bills that are not itemized
- Incomplete bills (missing information)
- Cash register receipt from pharmacy
- Incomplete receipt from pharmacy
- Collection notices

### Important Information

**Non-covered Expenses**

The following is a list of some non-covered expenses

- Treatment not directly related to the crime on which the claim is based
- Over-the-counter items not prescribed by a treating physician
- Mileage for court appearances
- Hotel accommodations
- Public transportation
- Food items
- Household items
- Household utilities
### Sexual Assault Program

**Sexual Assault Forensic Medical Evidence Collection Examination**

(Payment Procedure ‘At A Glance’)

<table>
<thead>
<tr>
<th>IF you are requesting payments for:</th>
<th>THEN you will need to provide:</th>
</tr>
</thead>
</table>
| **Sexual Assault Forensic Medical Examination** | **Sexual Assault Forensic Medical Examination**  
(Evidence collected within 120 hours of the assault)  
(18 and older) |
| **Sexual Assault (Acute) Protocol:** **Anonymous Reporting Protocol:** | **Sexual Assault (Acute) Protocol:** **Anonymous Reporting Protocol:** |
| Criteria for payments:  
- The assault occurred in South Carolina  
- SLED approved protocol followed  
- The claim was filed with SOVA within 180 days from the date of service | Payment Requirements  
- SOVA Sexual Assault Protocol (SAP) Billing Statement must be submitted,  
- SOVA Medical Examination Release Form must be submitted, and  
- Payment requested within 180 days from the date of service. |
| Pursuant to South Carolina law which follows the guidance of the federal Violence Against Women Act statute, victims of assault in the State of South Carolina may request, at no cost to them, a forensic examination for sexual assault, regardless of their involvement with law enforcement. SOVA is the sole reimbursement provider for forensic examinations in South Carolina. Health Care Providers will bill SOVA directly for individual charges for lab work, emergency room fee, physician’s fee, etc. Any fees beyond the actual collection of any evidence during a forensic examination will be the responsibility of the victim. Should law enforcement be involved, the option of SOVA victim compensation reimbursement becomes available. | Important  
SOVA Medical Examination Release Form must be submitted with the following information:  
The name of the Law Enforcement Agency. For anonymous reporting, when providing law enforcement information, write in “ANONYMOUS” instead of the name of the law enforcement agency.  
To establish that the crime happened in SC, the incident location (city, county and state) is required. |
| **Sexual Assault (Chronic) Protocol** | **Sexual Assault (Chronic) Protocol**  
(Evidence Collected after 72 hours of the assault)  
(17 and younger) |
| Criteria for payments:  
- The assault occurred in South Carolina  
- The assault was reported to law enforcement  
- The exam was ordered by law enforcement | Payment Requirements  
- Pages 1 and 2 of the Child Maltreatment Protocol billing statement is submitted,  
- Authorization and release form located in the Child Maltreatment Protocol is submitted,  
- Law Enforcement Incident Report listing each child as a victim, and  
- Payment must be requested within 180 days from the date of service. |
| Stipulations: SOVA will only pay for allowable charges incurred, in gathering evidence, when done at the request of law enforcement. |  |
| **Forensic Interview Evidence Collection Protocol** | **Forensic Interview Evidence Collection Protocol** (Interventions ordered by law enforcement for children 17 years old and younger) |
| Criteria for payments:  
- The assault occurred in South Carolina  
- The assault was reported to law enforcement  
- The forensic interview was ordered by law enforcement | Payment Requirements  
- Submit a billing invoice,  
- SOVA Forensic Interview Release Form,  
- SOVA Forensic Interview Report Form,  
- Law Enforcement Incident Report listing each child as a victim, and  
- Payment must be requested within 180 days from the date of Service |
| **Standards**  
- The interview must be performed using standards defined by SOVA.  
- Interviewer must have a Masters level degree  
- Interviewer must have completed a 40 hour specialized forensic interview training and must be licensed  
- Interviews must be conducted at a facility that follows a multi-disciplinary model and has been approved by SOVA | Stipulations: SOVA will only pay for allowable charges incurred, in gathering evidence, when done at the request of law enforcement. |
# Helpful Hints for Providers:

SOVA assists victims of crime with out-of-pocket expenses, including crime-related Medical/Clinical/Dental treatment. All claims or applications for assistance must meet the eligibility criteria prior to consideration with crime related compensable expenses.

| If you are billing SOVA for the first time, before you submit a bill | You will be required to register your business with the South Carolina State Government Procurement System at:  [http://procurement.sc.gov/PS/vendor/PS-vendor-registration.phtm](http://procurement.sc.gov/PS/vendor/PS-vendor-registration.phtm)  
Then click on “New Vendor Registration”—the process consist of 9 basic steps, some of which are optional. Below are what’s required:  
• Your company’s name and tax identification number  
• Information on the person responsible for maintaining the profile  
• Remit address (where checks should be mailed)  
• Entity designation (individual/sole proprietor, partnership, corporation) |
| --- | --- |
| Change in ‘Remit’ address(s) | You will be required to update your new information on the South Carolina State Government Procurement System at:  [http://procurement.sc.gov/PS/vendor/PS-vendor-registration.phtm](http://procurement.sc.gov/PS/vendor/PS-vendor-registration.phtm)  
• Click on “Update Vendor Information”  
• It may take up to 3 business days to update your information |
| If you have been assigned a new tax identification number (TIN) | You will be required to update your new information on the South Carolina State Government Procurement System at:  [http://procurement.sc.gov/PS/vendor/PS-vendor-registration.phtm](http://procurement.sc.gov/PS/vendor/PS-vendor-registration.phtm)  
• Click on “Update Vendor Information”  
• It may take up to 3 business days to update your information |
| New Owner of an existing business | You will be required to register your business with the South Carolina State Government Procurement System at:  [http://procurement.sc.gov/PS/vendor/PS-vendor-registration.phtm](http://procurement.sc.gov/PS/vendor/PS-vendor-registration.phtm)  
• Click on “New Vendor Registration” |
| State Employees | Providers who are state employees and who are sole proprietors, such as counselors, will be required to complete a dual employment application. |
| Unresolved Tax Issues/Tax Levy | Because SOVA is a state agency, providers who have unresolved tax issues might be required to resolve those issues before receiving payment from SOVA. |
| Conflict with the IRS | A provider could be required to provide verification from the IRS confirming that your Employer Identification Number (EIN) (TIN) is active. Information regarding your (EIN) (TIN) can be obtained from the IRS. (For information on how to obtain information from the IRS about the status of your EIN, see information below) 1-800-829-4933 (Business and Specialty Tax Line), then  
• Select option 1 for English, then  
• Select option 1 for EIN Department, then  
• Select option 3 for assistance with your request for a confirmation letter, then Request a 4158C, 147C or an EIN letter. Upon your request, you will receive a faxed cover sheet with the requested information and a letter will be sent to you from the IRS within 10 days.  
• And finally, you may fax the information to SOVA at (803) 734-2261. Pending payments will be mailed upon confirmation of your Employer Identification Number. |
### Documentation needed from Medical/Clinical/Dental providers:

Upon filing a claim, victims/claimants are required to provide SOVA with medical/Dental claim forms. One of the following forms is required for all separate crime related dates of service.

- UB-04 Medical Claim Form
- UB-92 Medical Claim Form
- Health Insurance Medical Claim Form (CMS-1500) (HCFA-1500)
- Itemized bill of Charges
- ADA Dental Claim Form (w/treatment plan)
- Itemized bill from vision center and when applicable,
- Health insurance information - Explanation Of Benefit (EOB)

### Documentation needed from Counselors:

For consideration with approved limits, providers will be required to provide the following:

- SOVA Mental Health Counselor’s Report for the initial 14 sessions
- SOVA Additional Counseling Sessions Request form for additional sessions
- Itemized bill of Charges or,
- Health Insurance Medical Claim Form (CMS/HCFA-1500)
- Explanation of Benefits (EOB) for each date of service

SOVA CANNOT CONSIDER PAYMENT if medical claim forms, itemized billing information, and health insurance explanation of benefits statements (if applicable) have not been received.

### Health insurance and EOBS

If the patient has health insurance, including Medicare or Medicaid, insurance must be billed. SOVA cannot consider payment until other payment sources, including health insurance, have been exhausted. For insured victims/claimants, SOVA must have a copy of relevant insurance explanation of benefits (EOB) statements for each crime-related date of service. These may be submitted by the victim/claimant or the medical provider; however, providers should note that submitting EOBS along with medical claim forms or itemized billing information is encouraged, as it may expedite claims processing and payment.

### Collections Activity: Section 16 3 1360:

**Collection activities prohibited**

(A) When a person files a claim pursuant to this article, a health care provider that has received written notice of a pending claim is prohibited from all debt collection activities relating to medical and psychological treatment received by the person in connection with the claim until an award is made on the claim or the claim is determined to be non-compensable and is denied, or ninety days have passed after the health care provider first received notice of a pending claim. The statute of limitations for collection of the debt is suspended during the period in which the applicable health care provider is required to refrain from debt collection activities.

(B) For purposes of this section, ‘debt collection activities’ means repeatedly calling or writing to the claimant and threatening to turn the matter over to a debt collection agency or to an attorney for collection, enforcement, or filing of other process. The term does not include routine billing or inquiries about the status of the claim.”

**NOTE:** If a victim/claimant has been placed in collections by a medical provider the account should be removed from collections immediately upon notification that a SOVA claim is pending.
### Negotiating Bills

Due to increased claims for uninsured victims of crime, SOVA is duty-bound to negotiate a reduction of payment on behalf of victims. The maximum award amount for eligible crime victims in the State of South Carolina is $15,000. Because most crime victims do not have any health insurance (private or public) and owe multiple providers more than the maximum payable dollar amount, SOVA request that providers accept negotiated payment/settlement agreements as payment in full for victims' outstanding crime related debt and not balance bill the victims.

### Release of Information

Each victim/claimant who submits a signed application to the State Office of Victim Assistance (SOVA), for assistance, authorize the State Office of Victim Assistance (SOVA) to request, obtain, and release any information or records to determine the eligibility of compensable bills.

### Payer of last resort status

The State Office of Victim Assistance is recognized as the payer of last resort, meaning that other collateral resources, restitution, subrogation, civil settlement, health insurance (public or private), and hospital charity care, when applicable, must be exhausted before SOVA will consider payment.

### Payment is prohibited prior to services being rendered

South Carolina's guidelines specifically prohibit payment prior to services being rendered. SOVA can only consider payment after services have been rendered and after required documentation has been received.

### Checking status of a claim/payment

Because SOVA's checks are dispersed by the State of South Carolina, it may take up to thirty days from the time the payment has been processed for a provider to receive a reimbursement check or electronic payment.

- SOVA does not notify medical providers automatically of claim status (awards or denials). Award notifications are sent to the victim/claimant, who has the responsibility to notify medical providers of the claim status.
- Due to the high volume of telephone inquiries medical providers are encouraged to submit faxed request for payment status. Medical providers seeking claim/payment status may send a faxed request to 803.734.1708. Status requests MUST include the victim’s name, date of birth and Social Security Number. If the SOVA claim number is known, please include that as well. Please allow time for the research to be completed in order to respond to your request.

### Timely Filing

SOVA highly recommends that claims be filed as soon as possible after services have been rendered to ensure prompt payments. However, SOVA requires providers to submit invoices and medical claim forms within 12 months from the date of service. Request for payment submitted after 12 months from the date of service will not be considered. For new victim compensation claims/applications: Claims (invoices/medical claim forms) for services provided must be submitted within 12 months after the date of eligibility.

### Under the Compensation & the Sexual Assault Program, payments could be delayed for the

Remit address was changed without notice  
Remit address on the bill does not match information on W-9  
Billing name/name of facility does not match information on W-9
| following reasons:                           | Change in Tax Identification Number |
|                                           | Provider name change                |
|                                           | Conflict with the IRS               |
|                                           | Tax Levy                            |
|                                           | Dual employment                     |

| Under the Compensation & the Sexual Assault Program, payments could be denied for the following reasons: | Missing law enforcement incident report for children 17 years of age or younger |
|                                                                                               | The victim’s name is not listed on the law enforcement incident report |
|                                                                                               | Received past the 180 days filing deadline |
|                                                                                               | Evidence collection protocol exam, for the crime date, has been paid |
|                                                                                               | Victim’s health insurance has paid |
|                                                                                               | Follow up visits not covered |
|                                                                                               | Chronic exam performed by someone other than a Physician, Nurse Practitioner, or SANE |
|                                                                                               | Crime did not occur in SC |

| Maximum award limits:                                         | Under the Compensation Program, all reimbursements are subtracted from the $15,000 maximum award amount. |
|                                                             | Under the Sexual Assault Program, SOVA reimburses from a fee schedule for evidence collection. For all medical treatment, as a direct result of physical injuries sustained during the assault, and for follow–up appointments, a victim compensation application will be required. |
SUPPORTING DOCUMENTS REQUIRED

- **Mental Health Counselor’s Report** form must be completed by the victim’s counselor and must certify whether the psychological trauma being addressed is a direct result of the crime. This form is used for consideration with the initial 14 mental health session’s limit. To request approval/preauthorization for payment of additional sessions, the ‘Additional Counseling Sessions Request Form’ must be submitted.
- **Medical claim form (HCFA-1500)/Itemized bill** from the mental health counselor detailing the actual dates of service, type of service provided (i.e. individual, group, medication management), the CPT code assigned, and the amount charged.
- **Explanation of Benefit (EOB):** Because SOVA is a payer of last resort, when the victim has health or dental insurance coverage (public or private), he/she will be required to provide SOVA with an Explanation of Benefits (EOB) from the Health insurance Company or provider for all crime related dates of service.

LICENSED PROFESSIONAL

**SECTION 16-3-1180(A)(1)** An award may be made for: reasonable and customary charges as periodically determined by the board for medical services, including mental health counseling, required and rendered as a direct result of the injury on which the claim is based, as long as these services are rendered by a licensed professional. Payment for mental health counseling is limited to the number of sessions during a one hundred eighty-day-period beginning on the date of the first counseling session or twenty sessions, whichever is greater. Upon recommendation of the director, the board may allow victims who max out the current benefit of twenty mental health counseling sessions to request up to an additional twenty sessions for a total of forty sessions;

**POLICY**

- The Provider must be a Licensed Mental Health Professional, and
- The Provider must have received specific training in evidence based treatment that has been shown to be effective in meeting the needs of crime victims.

INCREMENTAL LIMIT POLICY:

SOVA’s mental health policy provides an incremental approach to outpatient mental health session limitations. This approach was implemented on July 1, 2012 and applies to all eligible and active claims. Please note that this approach complies with SOVA’s law.

This policy in no way replaces SECTION 16-3-1180; it is in compliance with the law:

As long as these services are rendered by a licensed professional; payment for mental health counseling is limited to the number of sessions during a one hundred eighty-day-period beginning on the date of the first counseling session or twenty sessions, whichever is greater. Upon recommendation of the director, the board may allow victims who max out the current benefit of twenty mental health counseling sessions to request up to an additional twenty sessions for a total of forty sessions:

- For the initial 14 mental health session’s limit, providers will be required to submit a Mental Health Counselor’s Report.
- Approval/Pre-Authorization will be required for each additional incremental limit.
- The request for additional sessions must be reviewed and approved before additional sessions can be considered for payment.
- SOVA will review each subsequent request with an emphasis on any extreme circumstance of the victim.
- Sessions provided beyond the authorized session’s incremental limit are subject to denial if the additional sessions provided are not approved.

**NOTE:** SOVA pays the outstanding balance from bills not fully covered by existing medical insurance. If a victim has private or public medical insurance to include Medicaid/Medicare, bills must first be filed with applicable companies/carriers before submission to the agency for possible payment.

**NOTE:** Family sessions are reimbursed using the individual counseling fee scale.

**NOTE:** SOVA does not reimburse LMSW’s practicing privately or independently for clinical services, including mental health counseling.

**NOTE:** Counseling sessions for offenders are not compensable under the Victim Compensation Program.
Revisions as of July 2014
SOVA no longer requires the use of CPT codes when billing for counseling sessions. Providers are simply required to provide a description of the service and time spent. Reimbursement amount will be based on a fixed fee scale per session and is considered after any other 3rd party payee responsibility.*

<table>
<thead>
<tr>
<th>Unit of Service</th>
<th>Unit of Service</th>
<th>Unit of Service</th>
<th>Unit of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Session (which can be up to 2 hours)</td>
<td>Half session (20-30 minutes)</td>
<td>Full Session (45-60 minutes)</td>
<td>½ Session (75-90 minutes)</td>
</tr>
</tbody>
</table>

### Fee Schedule for Services Per Unit

#### Individual Counseling:
- LMSW, LPCI - $75.00 per unit
- Supervised PHD (Psychi/o) Candidate Interns - $75.00 per unit
- LPC, LCSW, LMFT, LISW - $90.00 per unit
- PHD Clinical Psychology - $105.00 per unit
- MD - $105.00 (Include: medication management) per unit

#### Group Counseling:
- LMSW, LPCI - $37.50 per unit
- Supervised PHD Candidate interns - $37.50 per unit
- LPC, LCSW, LMFT & LISW - $45.00 per unit
- PHD Clinical Psychology - $52.50 per unit
- MD - $52.50/hr. (Include: medication management) per unit

### Payer of Last Resort Status
*The State Office of Victim Assistance is the payer of last resort. If the victim has insurance, and the victim elects not to use his/her insurance for treatment, SOVA will not cover the cost. It is the provider’s responsibility to ensure that other avenues of payments are explored and used.

### Clinicians Billing SOVA For The First Time After October 1, 2014

Must submit documented evidence of the following:

- Copy of professional license
- Specific training in the use of evidence based treatment models that have been shown to be effective in meeting the needs of crime victims.

### Timely Filing

SOVA highly recommends that claims be filed as soon as possible after services have been rendered to ensure prompt payments when authorized. However, SOVA requires providers to submit invoices and medical claim forms within 12 months from the date of service. Requests for payment submitted after 1 year from the date of service will not be considered.

For new victim compensation claims/applications: Claims (invoices/medical claim forms) for services provided must be submitted within 12 months after the date of eligibility.

### Payment Stipulation

Providers seeking reimbursement from SOVA must agree to all Mental Health Counseling guidelines and not balance bill the victim.
<table>
<thead>
<tr>
<th>ADA Code</th>
<th>Description</th>
<th>SOVA Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0140</td>
<td>Limited oral evaluation-problem focused</td>
<td>44</td>
</tr>
<tr>
<td>D0150</td>
<td>Comprehensive oral evaluation</td>
<td>63</td>
</tr>
<tr>
<td>D0160</td>
<td>Detailed and extensive oral evaluation problem focused</td>
<td>142</td>
</tr>
<tr>
<td>D0210</td>
<td>Intraoral – complete series (including bitewings)</td>
<td>96</td>
</tr>
<tr>
<td>D0220</td>
<td>Intraoral periapical first film</td>
<td>25</td>
</tr>
<tr>
<td>D0230</td>
<td>Introral periapical additional film</td>
<td>23</td>
</tr>
<tr>
<td>D0250</td>
<td>Extraoral First Film</td>
<td>43</td>
</tr>
<tr>
<td>D0260</td>
<td>Extraoral Additional Film</td>
<td>40</td>
</tr>
<tr>
<td>D0270</td>
<td>Bitewing 1 Film</td>
<td>21</td>
</tr>
<tr>
<td>D0277</td>
<td>Vertical bitewings</td>
<td>72</td>
</tr>
<tr>
<td>D0330</td>
<td>Panoramic film</td>
<td>83</td>
</tr>
<tr>
<td>D2330</td>
<td>Resin-based composite-1 surface anterior</td>
<td>117</td>
</tr>
<tr>
<td>D2331</td>
<td>Resin-based composite-2 surfaces anterior</td>
<td>144</td>
</tr>
<tr>
<td>D2332</td>
<td>Resin-based composite-3 surfaces anterior</td>
<td>177</td>
</tr>
<tr>
<td>D2335</td>
<td>Resin-based composite-4 or more surfaces</td>
<td>215</td>
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<tr>
<td>D2391</td>
<td>Resin-based composite-one surface, posterior</td>
<td>144</td>
</tr>
<tr>
<td>D2392</td>
<td>Resin-based composite one surface, posterior</td>
<td>180</td>
</tr>
<tr>
<td>D2393</td>
<td>Resin-based composite-three surface, posterior</td>
<td>185</td>
</tr>
<tr>
<td>D2394</td>
<td>Resin-based composite-four or more surfaces, posterior</td>
<td>286</td>
</tr>
<tr>
<td>D2710</td>
<td>Crown-resin (indirect)</td>
<td>414</td>
</tr>
<tr>
<td>D2740</td>
<td>Crown-porcelain/ceramic substrate</td>
<td>929</td>
</tr>
<tr>
<td>D2750</td>
<td>Crown-porcelain/fuse high noble mtl</td>
<td>887</td>
</tr>
<tr>
<td>D2751</td>
<td>Crown porcelain fused to predominantly base metal</td>
<td>881</td>
</tr>
<tr>
<td>D2752</td>
<td>Crown-porc/noble metal</td>
<td>887</td>
</tr>
<tr>
<td>D2910</td>
<td>Recement inlay</td>
<td>81</td>
</tr>
<tr>
<td>D2920</td>
<td>Recement crown</td>
<td>91</td>
</tr>
<tr>
<td>D2950</td>
<td>Core buildup, including any pins</td>
<td>200</td>
</tr>
<tr>
<td>D2952</td>
<td>Cast post &amp; core in additional to crown</td>
<td>338</td>
</tr>
<tr>
<td>D2954</td>
<td>Prefabricated post &amp; core in additional to crown</td>
<td>185</td>
</tr>
<tr>
<td>D2962</td>
<td>Porcelain laminate vene (labial veneer-laboratory)</td>
<td>800</td>
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<tr>
<td>D3330</td>
<td>Molar root canal</td>
<td>798</td>
</tr>
<tr>
<td>D3310</td>
<td>Anterior root canal (excluding final restoration)</td>
<td>539</td>
</tr>
<tr>
<td>D3320</td>
<td>Bicuspid root canal (excluding final restoration)</td>
<td>651</td>
</tr>
<tr>
<td>D4263</td>
<td>Bone replacement graft-first site in quadrant</td>
<td>***</td>
</tr>
<tr>
<td>D5110</td>
<td>Complete upper denture/maxillary</td>
<td>1020</td>
</tr>
<tr>
<td>D5120</td>
<td>Complete lower denture/mandibular</td>
<td>1020</td>
</tr>
<tr>
<td>D5211</td>
<td>Partial upper denture-resin base (clasps &amp; rests)</td>
<td>917</td>
</tr>
<tr>
<td>D5212</td>
<td>Partial lower denture</td>
<td>1066</td>
</tr>
<tr>
<td>D5214</td>
<td>Partial lower denture, cast metal frame with resin base</td>
<td>1014</td>
</tr>
<tr>
<td>D5225</td>
<td>Max partial denture (valplast)</td>
<td>782</td>
</tr>
<tr>
<td>D5226</td>
<td>Mand. Partial denture (valplast)</td>
<td>782</td>
</tr>
<tr>
<td>D5520</td>
<td>Repair broken or missing teeth</td>
<td>99</td>
</tr>
<tr>
<td>D5610</td>
<td>Repair resin denture base</td>
<td>129</td>
</tr>
<tr>
<td>D5650</td>
<td>Add tooth, existing partial denture</td>
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</tr>
<tr>
<td>D5810</td>
<td>Interim complete denture</td>
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<tr>
<td>D5811</td>
<td>Interim complete denture</td>
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</tr>
<tr>
<td>D6040</td>
<td>Implant/surgical placement</td>
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<tr>
<td>D6053</td>
<td>Implant</td>
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<tr>
<td>D6057</td>
<td>Placement/custom abutment</td>
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<td>D6058</td>
<td>Abutment supported porcelain/ceramic crown</td>
<td>709</td>
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<tr>
<td>ADA Code</td>
<td>Description</td>
<td>SOVA Rate</td>
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<tr>
<td>---------</td>
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<tr>
<td>D6067</td>
<td>Implant-crown high noble metal</td>
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<td>D6078</td>
<td>Implant-supported removable partial</td>
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<tr>
<td>D6240</td>
<td>Pontic bridge porc. &amp; prec metal</td>
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<td>D6241</td>
<td>Pontic-porcelain fused to base</td>
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<td>Pontic-resin w/noble metal</td>
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<td>D6545</td>
<td>Retainer-cast metal resin</td>
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<tr>
<td>D6750</td>
<td>Crown porcelain fused/retainer; porc-hi nobel/brg-crn</td>
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<td>D6751</td>
<td>Crown-porcelain fused – abutment crn-porc fuse-base met</td>
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<td>D6760</td>
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<tr>
<td>D7140</td>
<td>Extraction, erupted tooth/extraction-single tooth</td>
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<tr>
<td>D7210</td>
<td>Extraction, surgical removal of erupted tooth</td>
<td>206</td>
</tr>
<tr>
<td>D7230</td>
<td>Extraction, removal of impacted tooth-partially bony</td>
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<td>D7250</td>
<td>Surgical removal of residual tooth roots</td>
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<tr>
<td>D7272</td>
<td>Tooth transplantation</td>
<td>513</td>
</tr>
<tr>
<td>D9215</td>
<td>Local anesthesia conjunction operative/surg pra</td>
<td>29</td>
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<tr>
<td>D9220</td>
<td>Deep sedation/general anesthesia/sedation IV</td>
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<td>D9221</td>
<td>Deep sedation/general anesthesia-ea add 15 min</td>
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<td>Inhalation of nitrous oxide/anxilysis analge</td>
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<td>D9241</td>
<td>IV conscious sedation/intravenous conscious sedation</td>
<td>341</td>
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<tr>
<td>D9242</td>
<td>IV conscious sedation/analg – ea add 15 min</td>
<td>131</td>
</tr>
<tr>
<td>D9420</td>
<td>Hospital Call</td>
<td>151</td>
</tr>
<tr>
<td>D9440</td>
<td>Office visit after regularly scheduled hours</td>
<td>51</td>
</tr>
<tr>
<td>20530</td>
<td>Removal foreign body</td>
<td>181</td>
</tr>
<tr>
<td>96360</td>
<td>IV infusion</td>
<td>54</td>
</tr>
<tr>
<td>99241</td>
<td>Office consul 15 min</td>
<td>44</td>
</tr>
<tr>
<td>99242</td>
<td>Office consul 30 min</td>
<td>83</td>
</tr>
<tr>
<td>99243</td>
<td>Office consul 40min</td>
<td>114</td>
</tr>
<tr>
<td>99358</td>
<td>Evaluation/management serv.</td>
<td>103</td>
</tr>
<tr>
<td>40805</td>
<td>Removal of embedded foreign body</td>
<td>798</td>
</tr>
</tbody>
</table>

Payer of Last Resort:
SOVA is an eligibility program. All submitted compensable expenses will be offset by other available sources before reimbursements/payments are considered. Pursuant to public and private dental/health insurance guidelines regarding In-Network providers, timely filing and pre-authorization, victims are encouraged to provide his/her provider their insurance information. Not doing so could mean a denial of our claim at SOVA. Victims will be required to file all compensable expenses with his/her private or public dental/health insurance company/carrier first; this includes Medicaid and Medicare. Victims’ compensable expenses are also offset by restitution, subrogation or civil settlements. Because SOVA is not a guarantor for crime victims’ compensable expenses, providers are encouraged to mail all bills to victims and forward ADA/UBs/HCFAs etc. to SOVA.

***Maximum Award Limits:
The maximum award amount for eligible crime victims in the State of South Carolina is $15,000. All reimbursements are subtracted from the maximum award amount. Due to increased claims for uninsured victims of crime, SOVA is duty-bound to negotiate a reduction of payment on behalf of victims. All crime related Oral and Maxillofacial surgery, Bone replacement graft and most implants are reimbursed at a 15% - 50% reduction provided that sufficient funds are available. To ensure reimbursement for crime related services, providers are encouraged to contact the office for pre-approval.
PART FOUR:

SAMPLE FORMS
PROCESSABLE FORMS
SOVA accepts the following forms when considering payment/reimbursement:

• ADA Dental Claim Form .................................................................................................................. 26
• UB-04 Medical Claim Form ........................................................................................................... 27
• UB-92 Medical Claim Form ........................................................................................................... 28
• SSA Consent for Release of Information Form OMB No. 0960-0566 ............................................ 39
• SOVA: Certificate of Clinical Necessity ........................................................................................... 30
• SOVA: Certificate of Dental Necessity ............................................................................................. 31
• SOVA: Mental Health Counselor’s Report ......................................................................................... 32
• SOVA: Additional Counseling Sessions Request Form .................................................................. 33
• SOVA: Funeral Bill Case Status Form ............................................................................................. 34
• SOVA: Memorandum of Understanding for Funeral Expenses ..................................................... 35
• SOVA: Employer’s Report – Lost Wages / Support ....................................................................... 36
• SOVA: Self-Employment Verification of Lost Wages .................................................................... 37
• SOVA: Physician’s Disability Report – Lost Wages ....................................................................... 38
• SOVA: Physician’s Disability - Loss of Support - Report ................................................................. 39
• SOVA: Sexual Assault Protocol Billing Statement (revised).......................................................... 40
• SOVA: Medical Examination Release Form (revised) .................................................................. 41
• SOVA: Forensic Interview Release Form (revised) ....................................................................... 42
• SOVA: Forensic Interview Billing Statement (revised) ................................................................... 43
• SOVA: Child Maltreatment Protocol Billing Statement (revised) ................................................ 44
• SOVA: Child Maltreatment Protocol Billing Statement Supplement (revised) ............................. 45
• Child Maltreatment Protocol Authorization and Release Form ...................................................... 46

UNPROCESSABLE FORMS
SOVA does not accept the following forms when considering payment/reimbursement:

• Final notices
• Statements
• Bills that are not itemized
• Incomplete bills (missing information)
• Cash register receipts from pharmacy
• Incomplete receipts from pharmacy
• Collection notices

Disclaimers:
Any information submitted on the forms is fictitious and intended for sample purposes only. Actual forms will reflect real data entered by providers. This site also includes forms from organizations other than SOVA and has been provided for sample purposes only.

The processable forms listed may change without notice and all submitted forms are subjected to verification, which may delay the process. SOVA may also require additional documentation.
ADA Dental Claim Form

2015 Edition

HEADER INFORMATION
1. Type of Transaction (Check all applicable boxes)
   □ Statement of Actual Services □ OR □ Request for Predetermination / Preauthorization
   □ EPSDT / Title XIX

2. Predetermination / Preauthorization Number

PRIMARY SUBSCRIBER INFORMATION
12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/YYYY)
14. Gender
   □ M □ F
15. Subscriber Identification (SSN or ID)

16. Plan/Group Number
17. Employer Name

OTHER COVERAGE
18. Relationship to Primary Subscriber (Check applicable box)
   □ Self □ Spouse □ Dependent Child □ Other

19. Student Status
   □ YES □ NO

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/YYYY)
22. Gender
23. Patient ID / Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED
24. Procedure Date (MM/DD/YYYY)
25. Area of Oral Cavity
26. Tooth System
27. Tooth Number(s) or Letter(s)
28. Tooth Surface
29. Procedure Code
30. Description
31. Fee

MISSING TEETH INFORMATION
32. (Place an ‘X’ on each missing tooth)
33. Remarks

AUTHORIZATIONS
34. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to the use and disclosure of my protected health information to carry out payment activities in connection with this claim.

35. Patient / Guardian signature
36. Date

ANCILLARY CLAIM / TREATMENT INFORMATION
38. Place of Treatment (Check applicable box)
   □ Provider’s Office □ Hospital □ ECF □ Other
39. Number of Enclosures (0 to 99)
40. Is Treatment for Orthodontics?
   □ No (Skip 41-42) □ Yes (Complete 41-42)
41. Date Apparel Placed (MM/DD/YYYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis?
   □ No □ Yes (Complete 44)
44. Date Prior Placement (MM/DD/YYYY)

45. Treatment Resulting from (Check applicable box)
   □ Occupational illness / injury □ Auto accident □ Other accident
46. Date of Accident (MM/DD/YYYY)
47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured subscriber)
48. Name, Address, City, State, Zip Code

49. Provider ID
50. License Number
51. SSN or TIN

52. Provider ID
53. License Number
54. Address, City, State, Zip Code

55. License Number
56. Address, City, State, Zip Code
57. Phone Number
58. Treatment Provider Specialty

© American Dental Association, 2002
JS15 (Same as ADA Dental Claim Form) D: JS16, JS17, JS18, JS19

To Reorder call 1-800-947-4746 or go online at www.adacatalog.org
**UB-92 Claim Form Example**

**County Hospital**
551 West Street
Anytown, IL 60066

**Doe Child**
1234 East Street, Anytown, IL 60066

<table>
<thead>
<tr>
<th><strong>Date of Service</strong></th>
<th><strong>Medical Record</strong></th>
<th><strong>DIagnosis Code</strong></th>
<th><strong>Code Description</strong></th>
<th><strong>Q Summary</strong></th>
<th><strong>Value Code</strong></th>
<th><strong>Amount</strong></th>
<th><strong>U C</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>02-24-2004</td>
<td>F</td>
<td>98710</td>
<td>Physical Therapy</td>
<td>071205</td>
<td>97</td>
<td>100</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>98710</td>
<td>Physical Therapy</td>
<td>071405</td>
<td>97</td>
<td>100</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>98710</td>
<td>Physical Therapy</td>
<td>072005</td>
<td>97</td>
<td>100</td>
<td>0</td>
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<tr>
<td></td>
<td></td>
<td>98710</td>
<td>Physical Therapy</td>
<td>072205</td>
<td>97</td>
<td>100</td>
<td>0</td>
</tr>
</tbody>
</table>

**Due From Patient**

- 400.00

**Abc**

<table>
<thead>
<tr>
<th><strong>Invoice Date</strong></th>
<th><strong>Level</strong></th>
<th><strong>Employer Name</strong></th>
<th><strong>Employer Location</strong></th>
</tr>
</thead>
</table>

**Remarks**

- Therapist - Ann Therapist
- Associate Level Provider - Peggy Associate

**UB-92 Code 1480**

OCCUPATIONAL

**CODIFICATION**

- Identify the certifications on the reverse apply to this SID and are made mandatory.
Social Security Administration
Consent for Release of Information

Please read these instructions carefully before completing this form.

When to Use This Form
Complete this form only if you want the Social Security Administration to give information or records about you to an individual or group (for example, a doctor or an insurance company).

Natural or adoptive parents or a legal guardian, acting on behalf of a minor, who want us to release the minor’s:
- nonmedical records, should use this form.
- medical records, should not use this form, but should contact us.

Note: Do not use this form to request information about your earnings or employment history. To do this, complete Form SSA-7050-F4. You can get this form at any Social Security office.

How to Complete This Form
This consent form must be completed and signed only by:
- the person to whom the information or record applies, or
- the parent or legal guardian of a minor to whom the nonmedical information applies, or
- the legal guardian of a legally incompetent adult to whom the information applies.

To complete this form:
- Fill in the name, date of birth, and Social Security Number of the person to whom the information applies.
- Fill in the name and address of the individual or group to which we will send the information.
- Fill in the reason you are requesting the information.
- Check the type(s) of information you want us to release.
- Sign and date the form. If you are not the person whose record we will release, please state your relationship to that person.

PRIVACY ACT NOTICE: The Privacy Act Notice requires us to notify you that we are authorized to collect this information by section 3 of the Privacy Act. You do not have to provide the information requested. However, we cannot release information or records about you to another person or organization without your consent for release of information. Your records are confidential. We will release only records that you authorize, and only to persons or organizations who you authorize to receive that information.

PAPERWORK REDUCTION ACT STATEMENT: This information collection meets the clearance requirements of 44 U.S.C. §3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U.S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213. You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21234-6401. Send only comments relating to our time estimate to this address, not the completed form.
Social Security Administration
Consent for Release of Information

TO: Social Security Administration

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth</th>
<th>Social Security Number</th>
</tr>
</thead>
</table>

I authorize the Social Security Administration to release information or records about me to:

NAME

ADDRESS

I want this information released because:

(There may be a charge for releasing information.)

Please release the following information:

_____ Social Security Number
_____ Identifying information (includes date and place of birth, parents' names)
_____ Monthly Social Security benefit amount
_____ Monthly Supplemental Security Income payment amount
_____ Information about benefits/payments I received from ___________ to ___________
_____ Information about my Medicare claim/coverage from ___________ to ___________
   (specify)
_____ Medical records
_____ Record(s) from my file (specify)
_____ Other (specify)

I am the individual to whom the information/record applies or that person's parent (if a minor) or legal guardian. I know that if I make any representation which I know is false to obtain information from Social Security records, I could be punished by a fine or imprisonment or both.

Signature: ____________________________
(Show signatures, names, and addresses of two people if signed by mark.)

Date: ___________ Relationship: ___________

Form SSA-3288 (5-2007) EF (5-2007)
SOVA: Certificate of Clinical Necessity  
07/14

State Office of Victim Assistance 1205 Pendleton St., Brown Bldg., Room 401, Columbia, SC 29201 803.734.1900

Crime Victim Information:

Victim: ____________________________  Claim#: ____________________________
SS# (last 5 digits): ____________________________  Crime Date: ____________________________
DOB: ____________________________  Crime Type: ____________________________

To the Treating Clinician: It appears that the victim has a pre-existing medical condition (a condition that existed prior to the crime or a condition that does not appear to be directly related to the crime on which his/her claim is based). To assist with this assessment, the victim is required to provide the agency with a Certificate of Clinical Necessity from his/her treating Physician/Clinician certifying that the treatment is directly related to the crime on which the claim is based and that the expense(s) incurred for the treatment are crime related.

(1) In your professional opinion, do you certify with a reasonable degree of professional certainty that the □ treatment or □ office visit was reasonable, necessary and was directly related to the injury sustained during the crime?
Crime Date: ________________  Type of Crime: ____________________________  □ Yes  □ No

(2) Diagnosis:

________________________________________________________
________________________________________________________
________________________________________________________
________________________________________________________
________________________________________________________
________________________________________________________

(3) Service Provided/Recommended Service: (Must include ICD-9 Codes/Procedure Codes)
ICD-9 Codes: __________ __________ __________
Procedure Codes: __________ __________ __________
List Medication(s): __________ __________ __________

(4) Clinician’s Statement of Justification: The treatment must be directly related to the above listed crime.
(Note: This means that the crime must have either caused the injury or aggravated a pre-existing condition.)

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

(5) Expected Duration of Treatment ________________ Months

I certify that any statement hereto has been reviewed and signed by me. I certify that the information is true, accurate and complete, to the best of my knowledge.

Type or print Clinician’s name ____________________________  Phone: (____) ______________
Clinician’s Signature ____________________________  Date: ________________
Clinician’s Address __________________________________________

Please have your Clinician fax this form to 803.734.2261  Form PSD001
State Office of Victim Assistance
1205 Pendleton St., Brown Bldg., Room 401, Columbia, SC  29201  803.734.1900

Crime Victim Information:

Victim: ___________________________  Claim#: ___________________________

SS#: (last 5 digits)__________________  Crime Date: _________________________

DOB: _______________________________  Crime Type: _________________________

To the Dentist: It appears that the victim has a pre-existing condition (a condition that existed prior to the crime or a condition that does not appear to be directly related to the crime on which his/her claim is based. To assist with this assessment, the victim is required to provide the agency with a Certificate of Dental Necessity from his/her treating provider certifying that the treatment is directly related to the crime on which the claim is based and that the expense(s) incurred for the treatment are crime related.

(1) In your professional opinion, do you certify with a reasonable degree of professional certainty that the □ treatment or □ office visit was reasonable, necessary and was directly related to the injury sustained during the crime?

Crime Date:______________  Type of Crime:_______________________________ □Yes □No

(2) Diagnosis:

________________________________________________________________________________________

________________________________________________________________________________________

(3) Service Provided/Recommended Service: Must include tooth number(s), procedure code(s) and description(s)

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

(4) Dentist’s Statement of Justification: The treatment must be directly related to the above listed crime. (NOTE: This means that the crime must have either caused the injury or aggravated a pre-existing condition)

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

(5) Expected Duration of Treatment ________________ Months

I certify that any statement hereto has been reviewed and signed by me. I certify that the information is true, accurate and complete, to the best of my knowledge.

Type or print Dentist’s name____________________________   Phone: (___)___________________

Dentist’s Signature___________________________________   Date:_______________________

Dentist’s Address________________________________________________________________________

Please have your Clinician fax this form to 803.734.2261          Form PSD002
Today’s Date _____ / _____ / ______

Victim’s Legal Name __________________________  Claimant (if a different person) ____________________

SS # (last 5 digits) ___ - ___ ___ ___ ___  Crime Date _____ / _____ / ______

To the Provider: This form is used for consideration with the initial 14 mental health session’s limit. To request approval/preauthorization for payment of additional sessions, the ‘Additional Counseling Sessions Request Form’ must be submitted.

This form must be submitted to request approval/preauthorization for payment of counseling sessions. The treatment must be directly related to the crime on which the claim is based. The information provided must include a goal-directed treatment plan and a summary of your assessment toward meeting those goals.

Approval/preauthorization is contingent upon the rationale behind the need and the details provided.

Is the trauma and the treatment a direct result of this crime?  YES _______  NO _______

Presenting Issue: ________________________________________________________________________
______________________________________________________________________________________

Description of psychological trauma as related to victimization: ______________________________________
______________________________________________________________________________________
______________________________________________________________________________________

Type of evidence based treatment model being used: ___________________________________________
______________________________________________________________________________________

Payer of Last Resort Status:
The State Office of Victim Assistance is the payer of last resort. If the victim has insurance, and the victim elects not to use his/her insurance for treatment, SOVA will not cover the cost. It is the provider’s responsibility to ensure that other avenues of payments are explored and used.

The following question must be answered:  Does this victim have health insurance coverage?  YES ____  NO _______

If the victim has health insurance, SOVA will pay after the insurance pays. Please provide the following information along with a copy of the EOB for each DOS:

Heath Insurance Carrier __________________________  Policy No. __________________________

Authorized Signature of Treating Therapist/Counselor  Printed Name of Payee    (__________)    Telephone No./Extension

License Type and Number ___________________________________________________ Mailing Address ____________________________________________________
City/State/Zip Code ________________________________________________________

Supervisor’s Signature  License Type and No.    Date
SOVA’s mental health policy provides an incremental approach to outpatient mental health sessions’ limitation. This form must be submitted to request approval/preauthorization for payment of additional sessions. Approval/preauthorization is contingent upon the rationale behind the need and the details provided. The information provided must include a goal-directed treatment plan and a summary of your assessment toward meeting those goals.

Specific training and qualification: The provider must be a Licensed Mental Health Professional, who has received specific training in evidence based treatment that have been shown to be effective in meeting the needs of criminal victimization on adults, children and families.

Victim’s Legal Name _______________________________ Claimant (if a different person) _______________________
SOVA Claim# _____________________________________ Crime Date: ______________________________________
Briefly describe the symptoms/conditions you are treating that are a direct result of the crime.

Provide the multiaxial diagnosis: ________________________________________________________________

Has there been substantial progress toward recovery from the crime related condition?
☐ YES      ☐ NO

Estimate duration of treatment: From _______ To _______  How many additional sessions are you requesting? __

Treatment Plan:

1) What is your diagnosis?
   _______________________________________________________________________________________

2) What is your Evidence Based Treatment model?
   _______________________________________________________________________________________

3) What is your training in the use of this model?
   _______________________________________________________________________________________

4) What is your plan for termination?
   _______________________________________________________________________________________

   _______________________________________________________________________________________

The Provider must provide the following information: The victim/claimant must sign and date this form:

Provider: Print Name, License Type - Number

Victim/Claimant: Name and Date

Name of Facility/Business

Phone Number
Decedent’s Name: ___________________________________________ DOB ____________________________

Person who signed the itemized funeral bill/contract/"Billing To" Person: ________________________________

Beginning Balance of the Bill: ____________________________________________________________________

Current Balance of the Bill: ____________________________________________________________________

Is Life Insurance Pending? ________________________________

Has Life Insurance Been Applied to the Account? ______________ If so, how much? _______________________

Who is the Beneficiary/Beneficiaries? ____________________________________________________________

Please list all paying parties and their contact information, dollar amount, and method of payment below:

<table>
<thead>
<tr>
<th>NAME</th>
<th>ADDRESS</th>
<th>PHONE NUMBER</th>
<th>DOLLAR AMOUNT</th>
<th>METHOD OF PAYMENT</th>
<th>DATE OF PAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Please attach a copy of the itemized funeral bill/contract)

Print Name and Title of Person Completing this Form ____________________________ Date ____________________________

State Office of Victim Assistance
1205 Pendleton St., Brown Bldg., Room 401, Columbia, SC 29201
Business Line: 803.734.1900
 www.sova.sc.gov

Please be advised that any information that is provided with fraudulent intent will be immediately reported to the SC Department of Labor, Licensing and Regulations.
Date: ___________________________

As a public service to the citizens of this state, SOVA has developed this "Memorandum of Understanding." This document does not replace SOVA’s Crime Victim Compensation Application.

This is a “Memorandum of Understanding” between ______________________ (Name of Establishment) and ______________________ (Claimant).

_____ I understand that the State Office of Victim Assistance (SOVA) is an eligibility program with criteria that must be met.

_____ I have been informed that if the compensation claim meets all of the criteria, there is a $4,000.00 maximum limit for funeral services and all balances are my responsibility.

_____ I understand that SOVA, in its sole discretion, pursuant to its laws, may grant a full award, reduce an award or deny a claim.

_____ I acknowledge that by signing this document, that:

1. This information has been explained to me by my victim advocate or by the Director of this establishment.

2. I agree to fully adhere to all rules and regulations of the State Office of Victim Assistance.

3. I understand that the eligibility process could take up to 120 days from the date that SOVA receives the compensation application.

I recognize that by signing this document, I acknowledge that submitting the Crime Victim Compensation application to SOVA is not an approval for payment, but the initial process for consideration with payment.

Signing this memorandum signifies or represents an understanding between the facility and the customer listed above.

__________________________________________________________________________

PROVIDER/DIRECTOR: Customer/Family Member:

__________________________________________________________________________

NAME (PRINT):          DATE             NAME (PRINT):          DATE

__________________________________________________________________________

SIGNATURE:              SIGNATURE:

Payer of Last Resort:

SOVA is an eligibility program. All eligible compensable expenses will be offset by other available sources before reimbursements/payments are considered. Recipients will be required to exhaust all available funds before the program will consider payments. This includes subrogation (monies awarded for civil actions), restitution (monies ordered by the courts), pre-need arrangements and donations.

State Office of Victim Assistance
1205 Pendleton St., Brown Bldg., Room 401
Columbia, SC  29201
Business Line: 803.734.1900
www.sova.sc.gov
**Criteria for Lost Wages**

There are four criteria that must be met: Employment (2) Missed time from work (3) Reportable income & (4) Disability

Legal name of the injured employee (crime victim) __________________________________________________________

Job Type______________________ Social Security # (Last 5 digits) __________________ Date of Birth ____/____/____

Date the above person was first employed by you ____/____/___________

Date he/she was first absent due to the crime related injury/injuries ____/____/___________

Date he/she returned to work part time (if applicable) ____/____/___________

Comment: _________________________________________________________________________________________

Date he/she returned to work full time ____/____/___________

Date he/she was terminated if no longer employed by you ____/____/___________

Please provide an explanation __________________________________________________________________________

---

Average work hours per week _________ Average hourly wage ___________ Gross salary per week _________________

Was this employee compensated for time absent from work? _____Yes _____ No

If you answered yes, complete the following:

<table>
<thead>
<tr>
<th>Deduction</th>
<th>Amount Per Week</th>
<th>From Date</th>
<th>To Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unemployment</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vacation</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sick</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td>$</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Employer__________________________ Address_________________________________ Phone (___) ______________

Person Completing Form (print) ___________________________ Signature______________________________

Title__________________________ Date_______ Employer Identification Number (required) _____________________

**Further documentation may be required to receive lost wages/support, i.e. two pay stubs prior to the crime or copies of your last two consecutive years of your federal income tax return transcript (contact IRS for additional information 1.800.829.1040)
This form applies to you:

- If you were self-employed at the time of the crime
- If you received your earnings in cash, personal checks or money order
- If you received your earnings in tips
- If you reported your income to the IRS

To support your request for lost wages, you must:

- Complete this form
- Return this form to SOVA (NOTARIZED), along with a completed Physician Disability Report from your Treating Physician
- Provide copies of the last two consecutive years of your federal income tax return transcript: (Free tax return transcripts may be requested from the Internal Revenue Services (IRS) by phone (1.800.829.1040 or 1.800.908.9946) or by mail using form 4506T available at http://www.irs.gov/pub/irs-pdf/f4506t.pdf.

Criteria for Lost Wages

There are four criteria that must be met:

(1) Employment (2) Missed time from work (3) Reportable income & (4) Disability

Section 1 Victim Information (the person requesting lost wages)

Legal Name ____________________________ Business Name ____________________________
SS# (last 5 digits) ___________ DOB _________ SOVA Claim Number _______________ Crime Date _______________
Home Address ____________________________________________ Contact # _______________
City ____________________________ State _______________ Zip Code _______________

Section 2 Description of your work

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Section 3 Describe how the crime directly impacted your ability to work

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

1) What was the starting date of your self-employment/business? _______________
2) What was the date you were first unable to report to work? _______________
3) What date did you return to work? _______________ part time _______________ full time
4) Average number of hours worked per week? _______________

SUBSCRIBED AND SWORN TO BEFORE ME BY __________________ _______________
THIS _______________________ DAY OF __________ __________________, 20_________.
MY COMMISSION EXPIRES _______________________________ ____________________
NOTARY PUBLIC ____________________________ ______________ (signature)
VICTIM/CLAIMANT ____________________________ _________________ (signature)
### Criteria for Lost Wages

There are four criteria that must be met:
1. Employment
2. Missed time from work
3. Reportable income
4. Disability

#### Legal name of (crime victim) injured patient

Social Security # (Last 5 digits) _______________ Date of Birth ____/____/____

Date the patient (crime victim) was first seen by you in relation to the crime____/____/____

Date of crime related injury ____/____/____ (must be completed)

Briefly describe the injury/injuries sustained as a direct result of the crime:_____________________________________________________________________________________________

__________________________________________________________________________________________________

Check all that applies in accordance to the patient’s physical ability:
- May resume work immediately without restrictions
- May resume work immediately with the following restrictions_________________________________________

Patient may return to work at full capacity on (date) ____/____/____
Patient may return to work at partial capacity on (date) ____/____/____
Patient has a return appointment on (date) ____/____/____

Type or print Treating Physician’s name____________________________________ Phone (____) ___________________

Signature of Treating Physician_______________________________________ Date_____________________________

Name and Address of Facility __________________________________________________________________________
This form applies to you:

If you are the Spouse of the direct victim or the Parent/Legal Guardian of a minor child victim who sustained a physical injury and requires individual care

If the direct victim’s Treating Physician certifies that it is medically necessary for you to provide individual care to the direct victim who sustained the injury

If it is medically necessary for you to miss more than two consecutive weeks from work

If you answered yes,

Provide the name of your patient:_______________________________________

Provide the date of the crime:__________________________________________

Legal Name_________________________________________ SS# (last 5 digits) _____________ DOB_______________

SOVA Claim Number__________________________________ Crime Date______________________________________

Home Address _________________________________________________Contact #_____________________________

City________________________________________  State________________________  Zip Code__________________

Describe the injury/injuries sustained as a direct result of the crime:_____________________________________________

__________________________________________________________________________________________________

Describe the care that is medically necessary to be provided by the spouse or parent/legal guardian of the direct victim:

__________________________________________________________________________________________________

__________________________________________________________________________________________________

Care will be required from ______/______/_______ through ______/______/_____

Type or print Treating Physician’s name_______________________________ Phone (____)________________________

Signature of Treating Physician ______________________________________ Date______________________________

Name and Address of Facility __________________________________________________________________________

Criteria: For lost wages there are four criteria that must be met: (1) Employment ** SOVA Employment Report or SOVA Self-Employment Verification of Lost Wages Form **(2) Missed time from work (3) Reportable income & (4) Disability.

Limitations: If you qualify, SOVA will consider loss of support benefits for a period not to exceed one month.

Payer of Last Resort Status: Because SOVA is a payer of last resort, all sources such as annual or sick leave, long/short term disability and SSA/SSI must be exhausted before SOVA will consider lost wage benefits.

Lost Wages Compensation Rate: SOVA uses an established based amount to calculate lost wage benefits.
Laboratory Services

- Gonorrhea Culture
  - Oral ($12)
  - Rectal ($12)
  - Vaginal ($12)

- Chlamydia Culture
  - Oral ($35)
  - Rectal ($35)
  - Vaginal ($35)

- NAAT ($50)
- Herpes Culture ($20)
- Vaginal Culture ($20)
- Wet Prep/KOH Prep ($10)
- Serum Pregnancy Test ($25)

Medical Services

- Gram Stain
  - Urethral ($10)
  - Rectal ($10)
  - Vaginal ($10)

- RPR, VDRL, Syphilis ($10)
- Presence of motile sperm ($5)
- Hepatitis B ($40)
- HIV HTLV1 ($20)
- Urinalysis ($18)
- Blood Drawing Fee ($5)
- Urine Culture ($20)
- Urine Pregnancy Test ($20)

Medications

<table>
<thead>
<tr>
<th>Medication</th>
<th>fee</th>
<th>Qty</th>
<th>Medication</th>
<th>fee</th>
<th>Qty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rocephine (Ceftriaxone) (injection)</td>
<td>$85 ea</td>
<td></td>
<td>Plan B Levonorgestrel</td>
<td>$25 ea</td>
<td></td>
</tr>
<tr>
<td>Flagyl (Metronidazole) (tabs/ea)</td>
<td>$3 ea</td>
<td></td>
<td>Ovral (Norgestrel) (tabs/each)</td>
<td>$1.75 ea</td>
<td></td>
</tr>
<tr>
<td>Phenergan (Promethazine) (tabs/ea)</td>
<td>$2.20 ea</td>
<td></td>
<td>Zithromax (Azithromycin) (tabs/ea)</td>
<td>$10 ea</td>
<td></td>
</tr>
<tr>
<td>Phenergan (suppository 50mg ea)</td>
<td>$12.74 ea</td>
<td></td>
<td>Lidocaine</td>
<td>$21 ea</td>
<td></td>
</tr>
<tr>
<td>Suprax (Cefixime) (tabs/ea)</td>
<td>$11.25 ea</td>
<td></td>
<td>Tetanus</td>
<td>$21 ea</td>
<td></td>
</tr>
<tr>
<td>Cipro (Ciprofloxin) (tabs/ea)</td>
<td>$8.00 ea</td>
<td></td>
<td>Other (Justification)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doxycycline (tabs/ea)</td>
<td>$2.64 ea</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B vaccine</td>
<td>$21.00 ea</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total Amount Billed: $__________

Health Care Provider must attach a copy of the Medical Examination Release Form to this Protocol Billing Statement for payment and forward to:

State Office of Victim Assistance
1205 Pendleton Street
Edgar A. Brown Building, Room 401
Columbia, SC 29201
State of South Carolina State Office of Victim Assistance
Medical Examination Release Form

In the matter of:

Patient

Name of Health Care Provider

Address

Address

City State Zip

City State Zip

In accordance with South Carolina Victims and Witnesses Bill of Rights, signed into law on June 22, 1984, I hereby voluntarily consent and authorize the South Carolina State Office of Victim Assistance (SOVA) and its authorized agents to receive my medical records. I also authorize SOVA to pay such medical expenses allowed by law to Health Care Providers for routine medical tests and examinations for evidentiary purposes as prescribed by South Carolina Law Enforcement Division (SLED)/South Carolina Hospital Association.

Dated this _______________ day of ____________________, 20__________________________, at ______________________________, South Carolina.

Signature of Patient/Guardian/Responsible Adult

Health Care Official’s Signature (SANE/MD)

Print Name of Law Enforcement Officer

Signature of Law Enforcement Officer

Name of Law Enforcement Agency (Do not abbreviate)

For Anonymous Reporting: write in “Anonymous”

Incident Location (County and State)

Date of Crime

The following questions MUST be answered:

Was the incident location in a federal, state, county or municipal jail, prison or other correctional facility?  

☐ Yes ☐ No

Was the patient confined in a federal, state, county, or municipal jail, prison or other correctional facility at the time of service?  

☐ Yes ☐ No

1, 2 If you answered NO to both questions, attach a copy of SOVA Sexual Assault Protocol (SAP) Billing Statement to this Medical Examination Release Form for payment and forward to:

STATE OFFICE OF VICTIM ASSISTANCE
1205 Pendleton Street, Rm. 401
Columbia, South Carolina 29201
Phone: (803)734-1900
In accordance with South Carolina Victims and Witnesses Bill of Rights, signed into law on June 22, 1984, I hereby voluntarily consent and authorize the South Carolina State Office of Victim Assistance and its authorized agents to receive my interview records and to pay directly such expenses allowed by law to the Children’s Advocacy Center for the forensic interview conducted for evidentiary purposes as prescribed by South Carolina State Office of Victim Assistance.

Dated this ________________ day of ______________________ , 20_____, at ________________

Signature of Patient/Guardian Forensic Interviewer’s Signature

The Children’s Advocacy Center must attach a copy of the Forensic Interview Billing Statement and a law enforcement incident/supplemental report to this Forensic Interview Release Form for payment and forward to:

STATE OFFICE OF VICTIM ASSISTANCE
1205 Pendleton Street
Edgar A. Brown Building, Room 401
Columbia, South Carolina 29201
Phone: (803)734-1900

*SOVA will not cover the cost of the interview if such is not requested by a law enforcement officer.
*If a child is in the legal custody of another government agency, the cost of the exam will not be covered by SOVA.
SOVA: Forensic Interview Billing Statement

Invoice Date: _______________       Invoice # _______________

Date of Service: _______________

Victim’s Legal Name: _______________________________________________________________

Age:____ Date of Birth:____/____/ ____   Gender___________  Race___________________________

SSN # (last 5 digits) ___- ___ ___ ___ ___                                                  Crime Date:___________

Did Law Enforcement contact you and/or the Children’s Advocacy Center to request this Interview? 1, 2

☐ Yes  ☐ No

Type of Allegation:
   Physical Assault __________
   Sexual Assault __________

Remit payment to:

Tax ID #: ____________________  Telephone #:(____)____-__________  

Total Charge $175.00

Name/Title of Interviewer _______________________________________________________________

Interviewer License # ____________________ Type__________________________

Or Supervisor name and license #___________________________________________________

The Children’s Advocacy Center must attach a copy of the Forensic Interview Release Form, and a law enforcement incident/supplemental report to this Forensic Interview billing statement for payment and forward to:

State Office of Victim Assistance
1205 Pendleton Street
Edgar A. Brown Building, Room 401
Columbia, South Carolina 29201

1 SOVA will not cover the cost of the interview if such is not requested by a law enforcement officer.
2 If a child is in the legal custody of another government agency, the cost of the interview will not be covered by SOVA.
# Child Maltreatment Protocol Billing Statement

<table>
<thead>
<tr>
<th>Child’s Name (last, first, MI):</th>
<th>SSN (last 5 digits):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth (mm/dd/yy):</td>
<td>Age:</td>
</tr>
<tr>
<td>Gender</td>
<td>Male</td>
</tr>
<tr>
<td>Race</td>
<td></td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td></td>
</tr>
<tr>
<td>Black/African American</td>
<td></td>
</tr>
<tr>
<td>Pacific Islander</td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td></td>
</tr>
<tr>
<td>Multiracial</td>
<td></td>
</tr>
<tr>
<td>White/Caucasian</td>
<td></td>
</tr>
<tr>
<td>Biracial</td>
<td></td>
</tr>
<tr>
<td>Other: Specify</td>
<td></td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td></td>
</tr>
<tr>
<td>Non-Hispanic</td>
<td></td>
</tr>
<tr>
<td>Other: Specify</td>
<td></td>
</tr>
<tr>
<td>Account Number:</td>
<td>Date of Crime (mm/dd/yyyy):</td>
</tr>
<tr>
<td>Facility Name:</td>
<td>Telephone Number: ( ) -</td>
</tr>
<tr>
<td>Place of Incident:</td>
<td>County:</td>
</tr>
<tr>
<td>Law Enforcement Agency (do not abbreviate):</td>
<td>Case Number:</td>
</tr>
</tbody>
</table>

## Evaluation For (check all that apply)

- Drug Endangered Child
- Pediatric Condition Falsification
- Threat of Harm
- Failure to Thrive
- Physical Abuse
- Physical Abuse
- Neglect
- Sexual Abuse
- Sexual Abuse
- Specify
- Other: Specify

## Other Miscellaneous Injuries

- Burns
- Fractures
- Lacerations/Wounds
- Contusions/Bruises
- Head/Scalp Injuries
- Scars
- Other: Specify

Did Law Enforcement contact you and/or the Children’s Advocacy Center to request this exam?  
- Yes
- No

Healthcare Provider Signature: Date:

Healthcare provider and/or facility must attach a copy of the Law Enforcement Incident Report and Authorization and Release Form to this billing statement for payment and forward to:

State Office of Victim Assistance  
1205 Pendleton Street  
Edgar Brown Building, Room 401  
Columbia, SC 29201

1 SOVA will not cover the cost of the exam if such is not requested by a law enforcement officer.  
2 If a child is in the legal custody of another government agency, the cost of the exam will not be covered by SOVA.
## Child Maltreatment Protocol Billing Statement

<table>
<thead>
<tr>
<th>Medical Services</th>
<th>Procedures</th>
<th>Miscellaneous Fees</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Healthcare Provider Fee ($105)</td>
<td>□ Emergency Room Fee ($75)</td>
<td>□ Forensic imaging with/without colposcopy ($90)</td>
</tr>
<tr>
<td>□ Clinic Fee ($50)</td>
<td>□ Colposcopy Fee ($90)</td>
<td>□ Supplies ($12)</td>
</tr>
</tbody>
</table>

### Laboratory Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gonorrhea Culture</td>
<td></td>
</tr>
<tr>
<td>Oral ($12)</td>
<td></td>
</tr>
<tr>
<td>Rectal ($12)</td>
<td></td>
</tr>
<tr>
<td>Vaginal ($12)</td>
<td></td>
</tr>
<tr>
<td>Chlamydia Culture</td>
<td></td>
</tr>
<tr>
<td>Rectal ($35)</td>
<td></td>
</tr>
<tr>
<td>Vaginal ($35)</td>
<td></td>
</tr>
<tr>
<td>NAAT ($50)</td>
<td></td>
</tr>
<tr>
<td>Trichomonas Vaginalis Culture/NAAT ($35)</td>
<td></td>
</tr>
<tr>
<td>Herpes Simplex Culture ($20)</td>
<td></td>
</tr>
<tr>
<td>Vaginal Culture ($20)</td>
<td></td>
</tr>
<tr>
<td>Wet Prep/KOH Prep ($10)</td>
<td></td>
</tr>
<tr>
<td>Urine Drug Screen ($50)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>GramStain</td>
<td></td>
</tr>
<tr>
<td>Urethral ($10)</td>
<td></td>
</tr>
<tr>
<td>Vaginal ($10)</td>
<td></td>
</tr>
<tr>
<td>RPR, VDRL, Syphilis ($10)</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B ($40)</td>
<td></td>
</tr>
<tr>
<td>HIV by Elisa ($20)</td>
<td></td>
</tr>
<tr>
<td>B-HCG, Blood ($25)</td>
<td></td>
</tr>
<tr>
<td>CBC ($35)</td>
<td></td>
</tr>
<tr>
<td>Platelet Count ($20)</td>
<td></td>
</tr>
<tr>
<td>SMA - Basic Metabolic Panel ($27)</td>
<td></td>
</tr>
<tr>
<td>Liver Function Test ($59)</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B ($40)</td>
<td></td>
</tr>
<tr>
<td>HIV by Elisa ($20)</td>
<td></td>
</tr>
<tr>
<td>B-HCG, Blood ($25)</td>
<td></td>
</tr>
<tr>
<td>Amylase ($22)</td>
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</tr>
<tr>
<td>PT &amp; aPTT ($40)</td>
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</tr>
<tr>
<td>Fibrinogen ($37.50)</td>
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<tr>
<td>HIV by Elisa ($20)</td>
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</tr>
<tr>
<td>B-HCG, Blood ($25)</td>
<td></td>
</tr>
<tr>
<td>Ristocetin Cofactor ($56)</td>
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<tr>
<td>Urinalysis ($18)</td>
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</tr>
<tr>
<td>Urine Culture &amp; Sensitivity ($20)</td>
<td></td>
</tr>
<tr>
<td>Urine Pregnancy Test ($20)</td>
<td></td>
</tr>
<tr>
<td>Blood Drawing Fee ($5)</td>
<td></td>
</tr>
<tr>
<td>von Willebrand Antigen ($126)</td>
<td></td>
</tr>
<tr>
<td>Wet Prep/KOH Prep ($10)</td>
<td></td>
</tr>
</tbody>
</table>

### Radiographs/Imaging Studies

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skeletal Survey Complete ($140)</td>
<td></td>
</tr>
<tr>
<td>Hand - Minimum 3 Views ($52)</td>
<td></td>
</tr>
<tr>
<td>Spine Entire AP LAT ($275)</td>
<td></td>
</tr>
<tr>
<td>Pelvis AP ($75)</td>
<td></td>
</tr>
<tr>
<td>Lumbar Spine ($95)</td>
<td></td>
</tr>
<tr>
<td>Skull - 4 Views ($80)</td>
<td></td>
</tr>
<tr>
<td>Pelvis &amp; Hips - Infant ($90)</td>
<td></td>
</tr>
<tr>
<td>Thoracic Spine ($90)</td>
<td></td>
</tr>
<tr>
<td>Chest PA &amp; Lateral ($29)</td>
<td></td>
</tr>
<tr>
<td>Femur ($25)</td>
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</tr>
<tr>
<td>CAT Scan ($500)</td>
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<tr>
<td>Humerus ($55)</td>
<td></td>
</tr>
<tr>
<td>Tibia Lower Leg ($25)</td>
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<tr>
<td>Cervical Spine ($90)</td>
<td></td>
</tr>
<tr>
<td>CAT Scan ($500)</td>
<td></td>
</tr>
</tbody>
</table>

**Total Amount Billed $**

Please remit payment to:

Tax ID Number:

Healthcare provider and/or facility must attach a copy of the Law Enforcement Incident Report/Supplemental Report, Authorization and Release Form, along with pages 1 and 2 of this Child Maltreatment Protocol Billing Statement for payment.
AUTHORIZATION AND RELEASE

I authorize ________________________________ to release medical information related to this incident to:

☐ State Office of Victim Assistance (SOVA)  ☐ Department of Social Services
☐ Law Enforcement  ☐ Solicitor
☐ Guardian ad Litem  ☐ SC Children's Advocacy Medical Response System

and hold harmless this facility and its staff, from any and all liability and claims of injury which may in any manner result from the release of such information.

I also authorize the release of medical information to:

☐ Private Physician  ☐ Mental Healthcare Provider
☐ Other Specify

for the continuing diagnosis and treatment of this child.

I request and authorize the State Office of Victim's Assistance (SOVA) to assign the payment for medical services provided on this child's behalf to:

Facility Name ________________________________
Address ________________________________
City _____________ State _______ Zip Code _______

I permit a copy of this authorization to be used. I understand that I have the right to withdraw this authorization at any time by notifying this facility in writing. I understand that the withdrawal is not effective for any actions taken prior to this withdrawal. Without a written notice to withdraw this authorization, it will expire 1 year from the date the medical service is provided.

Child's Name: ________________________________ Date of Birth: _____________ SSN:(Last 5 Digits) : _____________
Address: ________________________________
Contact Phone Number ________________________________

By signing, I consent to the authorization and release of medical information of the named child as described above.

Signature of Parent/Legal Representative ________________________________ Printed Name ________________________________ Date: _____________

Signature of Parent/Legal Representative ________________________________ Printed Name ________________________________ Date: _____________

Signature of Witness ________________________________ Printed Name ________________________________ Date: _____________