



Sexual Assault Protocol (SAP) Billing Claim Form

Name (Last, First, MI): _____
 DOB: _____ Age: _____
 Ethnicity: _____
 Home Address: _____
 City: _____ State: _____ Zip: _____
 Name of Healthcare Provider: _____
 Contact Number: _____

SS# (last 5 digits): _____
 Gender: Male Female Other _____
 Race: _____
 ACC#: _____
 Date of Service (mm/dd/yy): _____

Laboratory Services

<input type="checkbox"/> Gonorrhea NAAT <input type="checkbox"/> Oral (\$14) <input type="checkbox"/> Rectal (\$14) <input type="checkbox"/> Vaginal (\$14)	<input type="checkbox"/> Gram Stain <input type="checkbox"/> Urethral (\$12) <input type="checkbox"/> Rectal (\$12) <input type="checkbox"/> Vaginal (\$12)
<input type="checkbox"/> Chlamydia NAAT <input type="checkbox"/> Oral (\$42) <input type="checkbox"/> Rectal (\$42) <input type="checkbox"/> Vaginal (\$42)	<input type="checkbox"/> RPR, VDRL, Syphilis (\$32) <input type="checkbox"/> Presence of motile sperm (\$6) <input type="checkbox"/> Hepatitis B surface Antibody (\$48) <input type="checkbox"/> Hepatitis B surface Antigen (\$48) <input type="checkbox"/> HIV 4 th gen antigen/antibody (\$30) <input type="checkbox"/> Urinalysis (\$22) <input type="checkbox"/> Blood Drawing Fee (\$6) <input type="checkbox"/> Urine Culture (\$28) <input type="checkbox"/> Urine Pregnancy Test (\$28)
<input type="checkbox"/> Trichomoniasis NAAT (\$60) <input type="checkbox"/> Herpes Culture (\$24) <input type="checkbox"/> Vaginal Culture (\$24) <input type="checkbox"/> Wet Prep/KOH Prep (\$12) <input type="checkbox"/> Serum Pregnancy Test (\$30)	

Medical Services

<input type="checkbox"/> Physician, FNP, NP Fee (\$137)
<input type="checkbox"/> Emergency Room Fee (\$90)
<input type="checkbox"/> SANE Fee (\$104)
<input type="checkbox"/> Colposcopy Fee (\$108)
<input type="checkbox"/> Clinic Fee (\$60)
<input type="checkbox"/> Supplies (\$14)

Medications

Medication	Fee	Qty	Medication	Fee	Qty	Total Amount Billed	
<input type="checkbox"/> Rocephine 250 mg IM (Ceftriaxone) (injection)	\$11.46 ea		<input type="checkbox"/> Plan B Levonorgestrel Flagyl	\$30.00 ea			\$
<input type="checkbox"/> Flagyl 500 mg (Metronidazole) (4tabs/ea)	\$4.00 ea		<input type="checkbox"/> Ovral (Norgestrel) (tabs/each)	\$2.10 ea			
<input type="checkbox"/> Phenergan (Promethazine) (tabs/ea)	\$2.64 ea		<input type="checkbox"/> Zithromax 500mg (Azithromycin) (2 tabs/ea)	\$12.00 ea			
<input type="checkbox"/> Phenergan (suppository 50mg ea)	\$15.28 ea		<input type="checkbox"/> Lidocaine	\$25.00 ea			
<input type="checkbox"/> Suprax (Cefixime) (tabs/ea)	\$13.50 ea		<input type="checkbox"/> Tetanus vaccine	\$38.35 ea			
<input type="checkbox"/> Cipro (Ciprofloxin) (tabs/ea)	\$9.60 ea		<input type="checkbox"/> Acetaminophen(Tylenol)	\$0.17ea			
<input type="checkbox"/> Doxycycline (tabs/ea)	\$3.17 ea		<input type="checkbox"/> Ibuprofen (Motrin)	\$0.25ea			
<input type="checkbox"/> Hepatitis B vaccine	\$54.64 ea		<input type="checkbox"/> Ondansetron (Zofran)	\$6.00ea			
			<input type="checkbox"/> Ulipristal acetate (Ella)	\$43.00ea			
			<input type="checkbox"/> Other (Justify) _____				

Remittance Address Required

 SCEIS #: _____

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

Department of Crime Victim Compensation (DCVC)
 Edgar A. Brown Building, 1205 Pendleton Street, Room 401, Columbia, SC 29201

Telephone 803-734-1900 • Facsimile 803-734-2261