



Child Maltreatment Protocol Billing Statement

Child's Name (last, first, MI) :		SSN (last 5 digits):	
Date of Birth (mm/dd/yy):	Age:	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Race		<input type="checkbox"/> Pacific Islander	
<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Black/African American	<input type="checkbox"/> White/Caucasian	
<input type="checkbox"/> Asian	<input type="checkbox"/> Multiracial		
<input type="checkbox"/> Biracial	<input type="checkbox"/> Other: <i>Specify</i>		
Ethnicity		<input type="checkbox"/> Other: <i>Specify</i>	
<input type="checkbox"/> Hispanic	<input type="checkbox"/> Non-Hispanic		
Account Number:		Date of Crime (mm/dd/yy):	
Facility Name:		Telephone Number: () -	
Place of Incident:		County:	State:
Law Enforcement Agency (do not abbreviate):		Case Number:	
Evaluation For (check all that apply)			
<input type="checkbox"/> Drug Endangered Child	<input type="checkbox"/> Pediatric Condition Falsification	<input type="checkbox"/> Threat of Harm	
<input type="checkbox"/> Failure to Thrive	<input type="checkbox"/> Physical Abuse	<input type="checkbox"/> Physical Abuse	
<input type="checkbox"/> Neglect	<input type="checkbox"/> Sexual Abuse	<input type="checkbox"/> Sexual Abuse	
<i>Specify:</i>	<input type="checkbox"/> Other: <i>Specify</i>		
Other Miscellaneous Injuries			
<input type="checkbox"/> Burns	<input type="checkbox"/> Fractures	<input type="checkbox"/> Lacerations/Wounds	
<input type="checkbox"/> Contusions/Bruises	<input type="checkbox"/> Head/Scalp Injuries	<input type="checkbox"/> Scars	
<input type="checkbox"/> Other: <i>Specify</i>			
Did Law Enforcement contact you and/or the Children's Advocacy Center to request this exam?^{1, 2} <input type="checkbox"/> Yes <input type="checkbox"/> 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:

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

¹ The Department of Crime Victim Compensation 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 the Department of Crime Victim Compensation.

**South Carolina Attorney General's Office
Department of Crime Victim Compensation (DCVC)**



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Child's Name (last, first, MI) :			
DOB (mm/dd/yy):		Date of Evaluation (mm/dd/yy):	
Medical Services		Procedures	Miscellaneous Fees
<input type="checkbox"/> Healthcare Provider Fee (\$137)	<input type="checkbox"/> Emergency Room Fee (\$90)	<input type="checkbox"/> Forensic imaging with/ without colposcopy (\$108)	<input type="checkbox"/> Supplies (\$14)
<input type="checkbox"/> Clinic Fee (\$60)		<input type="checkbox"/> Colposcopy Fee (\$108)	
Laboratory Services			
<input type="checkbox"/> Gonorrhea Culture <input type="checkbox"/> Oral (\$14) <input type="checkbox"/> Rectal (\$14) <input type="checkbox"/> Vaginal (\$14)	<input type="checkbox"/> GramStain <input type="checkbox"/> Urethral (\$12) <input type="checkbox"/> Vaginal (\$12)	<input type="checkbox"/> CBC (\$42)	<input type="checkbox"/> Platelet Count (\$24)
<input type="checkbox"/> Chlamydia Culture <input type="checkbox"/> Rectal (\$42) <input type="checkbox"/> Vaginal (\$42)	<input type="checkbox"/> RPR, VDRL, Syphilis (\$12)	<input type="checkbox"/> SMA - Basic Metabolic Panel (\$32)	<input type="checkbox"/> Liver Function Test (\$71)
<input type="checkbox"/> NAAT (\$60)	<input type="checkbox"/> Hepatitis B (\$48)	<input type="checkbox"/> Amylase (\$26)	<input type="checkbox"/> PT & aPTT (\$48)
<input type="checkbox"/> Trichomonas Vaginalis Culture/NAAT (\$42)	<input type="checkbox"/> HIV by Elisa (\$24)	<input type="checkbox"/> Fibrinogen (\$45)	<input type="checkbox"/> von Willebrand Antigen (\$151)
<input type="checkbox"/> Herpes Simplex Culture (\$24)	<input type="checkbox"/> B-HCG, Blood (\$30)	<input type="checkbox"/> Ristocetin Cofactor (\$67)	<input type="checkbox"/> Blood Drawing Fee (\$6)
<input type="checkbox"/> Vaginal Culture (\$24)	<input type="checkbox"/> Urinalysis (\$22)	<input type="checkbox"/> Urine Drug Screen (\$60)	
<input type="checkbox"/> Wet Prep/KOH Prep (\$12)	<input type="checkbox"/> Urine Culture & Sensitivity (\$24)		
	<input type="checkbox"/> Urine Pregnancy Test (\$24)		
Radiographs/ Imaging Studies			
<input type="checkbox"/> Skeletal Survey Complete (\$168)	<input type="checkbox"/> Hand - Minimum 3 Views (\$62)	<input type="checkbox"/> Spine Entire AP LAT (\$330)	
	<input type="checkbox"/> Pelvis AP (\$90)	<input type="checkbox"/> Lumbar Spine (\$114)	
<input type="checkbox"/> Skull - 4 Views (\$96)	<input type="checkbox"/> Pelvis & Hips - Infant (\$108)	<input type="checkbox"/> Thoracic Spine (\$108)	
<input type="checkbox"/> Chest PA & Lateral (\$35)	<input type="checkbox"/> Femur (\$30)	<input type="checkbox"/> CAT Scan (\$500) Head	<input type="checkbox"/> CAT Scan (\$500) Abdomen
<input type="checkbox"/> Humerus (\$66)	<input type="checkbox"/> Tibia Lower Leg (\$30)		
<input type="checkbox"/> Forearm (\$30)	<input type="checkbox"/> Cervical Spine (\$108)		
			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.