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## Illinois HFS Sexual Assault Emergency Treatment Program AUTHORIZATION FOR PAYMENT VOUCHER

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**Authorization #:**

**Date of Hospital Service:**

**Patient's Name:**

**Hospital :**

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Dear Provider:

This patient has recently received hospital emergency services through the Illinois HFS Sexual Assault Emergency Treatment Program and has been advised to seek follow-up healthcare services. This Authorization for Payment Voucher (Voucher) allows you to provide appropriate follow-up healthcare **related to the sexual assault** to ensure the patient's well being and to be reimbursed directly by the Illinois HFS Sexual Assault Emergency Treatment Program for those healthcare services.

If additional follow-up healthcare services are required (e.g., exam, laboratory, pharmacy), please make a copy of this Voucher for your billing purposes and allow the patient to retain the original Voucher. If you directly order laboratory services, please make an additional copy of this Voucher to accompany your request to the laboratory. The patient will keep the original Voucher in case additional follow-up healthcare services **related to the sexual assault** are needed. This Voucher is valid for 90 days, with the "date of hospital service" above counted as day one. The expiration date for this voucher is: **MM/DD/YYYY**

**Do not bill the sexual assault survivor presenting this Voucher** for follow-up healthcare services you render related to the sexual assault. Illinois law requires that healthcare services to a sexual assault survivor covered by the Illinois HFS Sexual Assault Emergency Treatment Program be provided at no charge to the sexual assault survivor. 89 Ill.Admin. Code §148.510. Each provider of follow-up healthcare services must send its bill (**electronic billing is not available**) along with a copy of this **Authorization For Payment Voucher** to the following address:

**ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES  
SEXUAL ASSAULT PROGRAM  
P.O. BOX 19129  
SPRINGFIELD, ILLINOIS 62794-9129**