**Office of Claims and Appeals – Crime Victims Compensation Board**
**Sexual Assault Exam Program**
**500 Mero St., 2SC1, Frankfort, KY 40601**
**Office 502-782-8255 Fax 502-573-4817**

Full Amount: $538.00
Partial Amount:

To be entered by CVCB
CVCB Case #

## COMPREHENSIVE CHILD SEXUAL ASSAULT MEDICAL EXAM/ TREATMENT BILLING FORM

Patient Name:

Patient Account #:

Fax completed forms and itemized bills to (502)573-4817. For Information, call (502) 782-8255 / (800) 469-2120

### CHILD ADVOCACY CENTER INFORMATION

CAC Name: Federal ID #:

Address: Phone #:

Contact:

City State Zip Code

**I certify that a CCSAME exam as defined in 907 KAR 3:160 was preformed, and that the sexual abuse was reported as required in KRS 620.030**

CAC Director (Print) Signature

### PATIENT INFORMATION

Name: Female_______ Male

First Middle Last

Social Security or Govt ID #: Date of Birth: Age: at time of crime

Address:

City State Zip Code

Telephone #: (Home) (Work) (Cell)

Parent/Guardian E-Mail:

Insurance: Medicaid: Date of Examination: Time: a.m./p.m.

### FEDERAL GOVERNMENT INFORMATION (optional/for statistical use only)

Ethnic Group (Patient)
( ) Caucasian
( ) African American
( ) American Indian or Alaskan Native
( ) Hispanic / Latino
( ) Multiracial
( ) Asian
( ) Native Hawaiian / Other Pacific Islander
( ) Other

Are you (please check all that apply)
( ) U.S. Citizen ( ) Handicap ( ) Kentucky Resident

Is this a Federal Crime? ( ) Yes ( ) No

### SEXUAL ASSAULT INFORMATION

Date of Assault: Time: a.m/p.m.

City: County: State: Kentucky

## MEDICAL CERTIFICATION

**Failure of the examiner to certify that a CCSAME, as set forth in 907 KAR 3:160, was preformed will result in the denial of your claim.**

I hereby certify that a CCSAME, as set forth in 907 KAR 3:160, was performed by me upon the above named patient on: , 20____

Physician, SANE, Physician Assistant or Advanced Practice Registered Nurse whose training and/or scope of practice includes performance of genital examination (print name)

License Number

Signature

**Fax or mail completed form with itemized bill to:**
Office of Claims and Appeals - CVCB
500 Mero St., 2SC1
Frankfort, KY 40601
Fax # 502-573-4817

**KRS 49.490: No charge shall be made to the victim for sexual assault examinations by the hospital, the sexual assault examination facility, the physician, the pharmacist, health department, the sexual assault nurse examiner, the victim's insurance carrier or the Commonwealth.**

**I authorize the release of this information to the Office of Claims and Appeals – Crime Victims Compensation Board for billing purposes.**

**Parent or Guardian's Signature**

**Date**