Office of Claims and Appeals – Crime Victims Compensation Board
500 Mero St., 2SC1, Frankfort, KY 40601

HIV POST-EXPOSURE FIRST FOLLOW-UP EXAM / TREATMENT BILLING FORM

Patient name: ________________________________

Phone number: ________________________________

To be entered by CVCB
CVCB case #

Attention authorized medical personnel administering treatment or service: check box for each service rendered. **Fax completed forms and itemized bills to (502) 573-4817.**

For information, call the Crime Victims Compensation Board at (502) 782-8255 / (800) 469-2120.

FIRST Follow-up Exam (7-10):	**Patient Account #**	
Category	Cost Reimbursement	Rendered
Exam	$50	
Labs (Western Blot)	$50	
As the medical personnel authorized by KRS 216B.400 to perform sexual assault exams, I certify completion of the above checked categories		
Printed Name		Signature
Facility (Payee) Address	Phone #	Federal ID #

Medication: Patient Account #		
Category	Cost Reimbursement	Rendered
21-day meds	$600	
I certify completion of the above checked category.		
Printed Name		Signature
Facility (Payee) Address	Phone #	Federal ID #

KRS49.490 <u>No charge shall be made to the victim for sexual assault examinations</u> by the hospital, the sexual assault examination facility, the physician, the pharmacist or the health department, the sexual assault nurse examiner, the victim's insurance carrier, or the Commonwealth.

I authorize the release of this information to the Crime Victims Compensation Board for billing purposes.

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Patient Signature　　　　　　　　　　　　　　　　Date