

**Office of Claims and Appeals – Crime Vic. Comp. Board**

500 Mero St., 2SC1, Frankfort, KY 40601

**HIV POST-EXPOSURE SECOND FOLLOW-UP EXAM / TREATMENT BILLING FORM**

Patient Name:

To be entered by CVCB

CVCB case #

**Authorized medical personnel administering treatment or service:** check box for each service rendered.  
**Fax completed forms and itemized bills to (502) 782-8255.** For information, call: (502)782-8255 / (800) 469-2120

Second Follow-up Exam (Day 13)		
Category	Cost Reimbursement	Rendered
Exam	\$50	
Labs (CBC, CMP, and pregnancy test)	\$90	
I certify completion of the above checked category.		
Printed Name		Signature
Facility (Payee) Address	Phone #	Federal ID #

**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 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.

\_\_\_\_\_

Patient Signature

\_\_\_\_\_

Date