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

Maximum Amount: $894.00

CVCB Case #

(To be added by CVCB)

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

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, email 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
Email: crimevictims@ky.gov / cathy.greene@ky.gov

KRS 216B.400(9): 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. The maximum rate that can be billed with proof of the amount actually billed or charged for the service is $894 pursuant to 907 KAR 3:160.

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**