PUBLIC PROTECTION CABINET
Kentucky Office of Claims and Appeals
Crime Victims Compensation Board
500 Mero Street, 2SC1
Frankfort, KY 40601
Phone: (502) 782-8255
Fax: (502) 573-4817

Andy Beshear
GOVERNOR

Jacqueline Coleman
LIEUTENANT GOVERNOR

Ray A. Perry
SECRETARY

DJ Wasson
DEPUTY SECRETARY

Allyson Taylor
EXECUTIVE DIRECTOR

CVCB Case #
(To be added by CVCB)

COMPREHENSIVE CHILD SEXUAL ASSAULT MEDICAL EXAM/ TREATMENT BILLING FORM

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 performed, 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:

crime Address: at time of

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

SEXUAL ASSAULT INFORMATION

Date of Assault:

City: County: State: Kentucky

Effective January 2025

MEDICAL CERTIFICATION

Failure of the examiner to certify that a CCSAME, as set forth in 907 KAR 3:160, was performed 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____

Printed name of physician, SANE, physician assistant or APRN

License Number

whose training and/or scope of practice includes performance of genital examination

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 in an amount not to exceed the Medicaid reimbursement rate for the service.

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**

Effective January 2025