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

To be entered by CVCB

CVCB case #

SAFE EXAM / TREATMENT BILLING FORM

Patient Account #:

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

FACILITY INFORMATION

Facility Name: Federal ID #:

Address: Phone #:

Contact:

City State Zip Code

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)

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

MEDICAL CERTIFICATION

Failure of the examiner to certify that the forensic sexual assault examination was performed, pursuant to 502 KAR 12:010, will result in the denial of your claim.

I hereby certify that I performed the forensic sexual assault examination on the above-named patient, pursuant to 502 KAR 12:010, on:

, 20____

Name of physician, SANE, physician ~~a~~ssistant or APRN 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.

I authorize the release of this information to the Office of Claims and Appeals - CVCB for billing purposes.

Patient Signature **Date**

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

SAFE EVIDENTIARY REPORT

GENERAL INFORMATION

Patient Name: Date of Birth:

Facility:

LAB ORDERS

_____ CBC w/o Diff, Hepatic Function Panel, Creatinine (Serum) (if giving HIV n PEP) _____ Radiology _____ Pathology

_____ Urine Pregnancy Test _____ Lab HcG _____ HIV 1-2 _____ Toxicology Testing _____ RPR

MEDICATION

_____ Rocephin _____Metronidazole _____Azithromycin _____ Lidocaine _____ Prophylaxis

_____ Plan B (levonorgestrel) Other :

_____ Promethazine _____Odansetron _____ NPEP Starter Kit

SAMPLES COLLECTED

Reference Samples: _____ Blood _____ Buccal _____ Hair

Source Samples: _____Oral _____ Vaginal _____Cervical _____ Anal Swabs _____ External Genital Swabs

EXAM / ASSESSMENTS

_____ Genital Examination _____ Inspect / Palpate _____ Toluidine Blue Dye _____ Triage

_____ Alternate Light Source _____ Photo Documentation _____ Head to Toe Assessment

_____ Speculum _____ Colposcope _____ Strangulation

FORENSIC EXAMINER INFORMATION

Printed Name and Title of Examiner **License Number**

Examiner Signature **Date**

Physician, SANE, Physician Assistant or Advanced Practice Registered Nurse whose training and/or scope of practice includes performance of genital examinations (Examiner Fee is set to the Medicaid reimbursement rate for such services)

Effective January 2025

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

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: 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

SEXUAL ASSAULT INFORMATION

Date of Assault:

City: County: State: Kentucky

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

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 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**

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

HIV POST-EXPOSURE INITIAL EXAM/TREATMENT BILLING FORM

To be entered by CVCB:
CVCB Case #:_____

Patient Name: _____
Phone Number: _____
Assault Date: _____

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

Initial Exam: Patient Account #

Category	Cost Reimbursement	Initials
Labs (Rapid HIV, CBC, CMP)	Medicaid reimbursement rate	

As the medical personnel authorized by KRS 216B.400 to perform sexual assault exams, I certify completion of the above checked category.

Printed Name Signature

Facility (Payee) Address Phone # Federal ID #

Medication: Patient Account #

Category	Cost Reimbursement	Initials
7-day meds starter pack	Medicaid reimbursement rate	
Anti-nausea (28 days)	Medicaid reimbursement rate	

I certify completion of the above checked categories

Printed Name Signature

Facility (Payee) Address Phone # Federal ID #

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 or 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/Parent Signature Date

Effective January 2025

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: _____
Assault Date: _____

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	Initials
Exam	Medicaid rate	
Labs (Western Blot)	Medicaid rate	
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	Initials
21-day meds	Medicaid rate	
I certify completion of the above checked category.		
Printed Name		Signature
Facility (Payee) Address	Phone #	Federal ID #

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 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/Parent Signature Date

Effective January 2025

Office of Claims and Appeals – Crime Victims Compensation Board

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

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

Patient Name: _____
Phone Number: _____
Assault Date: _____

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) 573-4817. For information, call: (502)782-8255.

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

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 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/Parent Signature Date

Effective January 2025

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

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

To be entered by CVCB
CVCB case #

Patient Name: _____
Phone Number: _____
Assault Date: _____

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 (502) 782-8255.

Third / Final Follow-up Exam (Day 28)

Category	Cost Reimbursement	Initials
Exam	Medicaid rate	
Labs CBC, CMP)	Medicaid rate	

I certify completion of the above checked categories.

Printed Name		Signature
Facility (Payee) Address	Phone #	Federal ID #

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 or 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/Parent Signature Date

THE PATIENT SHALL RETAIN THIS FORM. PROVIDERS MAY MAKE COPIES FOR THEIR FILES

HIV POST-EXPOSURE EXAM/TREATMENT VOUCHER

This voucher verifies that _____ qualifies for HIV post-exposure treatment covered by the Crime Victims Compensation Board for the following services and payment schedule (107 KAR 2:010)

(1) Initial Exam: laboratory testing, 7-day starter pack and 28-day anti-nausea medication/prescription
(2) First follow-up visit: exam and 21-day medication/prescription
(3) Second follow-up visit: exam and laboratory testing
(4) Third and final follow-up visit: exam and laboratory testing

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 or health department, the sexual assault nurse examiner, the victim's insurance carrier, or the Commonwealth.

_____ _____

Printed name of physician, sexual assault nurse examiner as defined in KRS 314.142, or other qualified medical professional as defined in KRS 216B.400, performing the sexual assault exam.

Signature

_____
Initial exam site

Date: _____

_____
Phone number

Forms must be downloaded by provider. For billing/payment information and forms, go to kycc.ky.gov

For questions, please contact the Crime Victims Compensation Board at (502) 782-8255

IMPORTANT PATIENT INFORMATION

- Once you begin the medication, it is important that you take it as prescribed until the entire prescription is gone.
- You will need support through your treatment. It is recommended that you contact your local rape crisis center. If you do not have a therapist or insurance to pay for one, payment can be considered through Crime Victims Compensation (CVC). If you have any questions about CVC, call (502) 782-8255.
- Follow-up visits to your physician or another medical practitioner are necessary to monitor your body's reaction to the medication and to be screened for other sexually transmitted diseases and (for women) pregnancy that could not be detected at the time of your visit to the emergency room. Use the following schedule for your visits:

  Days following the initial visit to the hospital/emergency room:

  Day 7-10: You will be examined and receive a prescription for the remaining 18 days of medication.

  Day 13: You will be examined and a blood screening will be done to monitor your overall health; women will be tested for pregnancy.

  Day 28: Another blood screening will be done to monitor your overall health.
- For your follow-up exams, if you do not have a physician, please contact the Kentucky Association for Sexual Assault Programs for the name of the physician specializing in HIV in your area at (502) 226-2704.
- If you have any other expenses related to the crime of which you were a victim, please contact the CVCB for information regarding payment at (502) 782-8255.

Effective January 2025