

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