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: _____
City/County where assault occurred: _____ 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/ (800) 469-2120

Initial Exam: Patient Account #

Category	Cost Reimbursement	Rendered
Labs (Rapid HIV, CBC, CMP)	$150	

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	Rendered
7-day meds starter pack	$200	
Anti-nausea (28 days)	$30	

I certify completion of the above checked categories

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 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

_____ _____
Parent Signature Date