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

Effective January 2025