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**