Kentucky Claims Commission - Crime Victims Compensation
Sexual Assault Exam Program
500 Mero St., 2SC1, Frankfort, KY 40601

To be entered by CVC

CVC case #

SAFE EXAM / TREATMENT BILLING FORM

Patient Name:

Patient Account #:

Fax completed forms and itemized bills to (502)573-4817. For Information, call (502) 782-8255 / (800) 469-2120

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

Is this a Federal Crime? ( ) Yes ( ) No

SEXUAL ASSAULT INFORMATION

Date of Assault: Time: a.m/p.m.

City: County: State: Kentucky

MEDICAL CERTIFICATION

Failure of the examiner to certify that the forensic sexual assault examination, as set forth in 502 KAR 12:010. Was preformed will result in the denial of your claim.

I hereby certify that the forensic sexual assault examination, as set forth in 502 KAR 12:010. Was performed by me upon the above named patient on: , 20____

Physician, SANE, Physician Assistant or Advanced Practice Registered Nurse whose training and/or scope of practice includes performance of genital examination (print name)

License Number

Signature

Fax or mail completed form with itemized bill to:

Kentucky Claims Commission/SAFE Exam Program
500 Mero St., 2SC1
Frankfort, KY 40601

Fax # 502-573-4817

KRS 346:200(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 Kentucky Claims Commission/ Crime Victims Compensation for billing purposes.

Patient Signature **Date**