

**Kentucky Claims Commission - Crime Victims Compensation  
Sexual Assault Exam Program  
130 Brighton Park Blvd., 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) Are you (please check all that apply)  
( ) Caucasian ( ) U.S. Citizen ( ) Handicap ( ) Kentucky Resident  
( ) African American  
( ) American Indian or Alaskan Native Is this a Federal Crime? ( ) Yes ( ) No  
( ) Hispanic / Latino  
( ) Multiracial  
( ) Asian  
( ) Native Hawaiian / Other Pacific Islander  
( ) Other

**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  
130 Brighton Park Blvd.  
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