

Kentucky Claims Commission / Kentucky Crime Victim Compensation
500 Mero St., 2SC1, Frankfort, KY 40601

HIV POST-EXPOSURE FIRST FOLLOW-UP EXAM / TREATMENT BILLING FORM

Patient name: _____

Phone number: _____

To be entered by CVC
CVC case #

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 Kentucky Claims Commission: (502) 782-8255 / (800) 469-2120.

FIRST Follow-up Exam (7-10):		Patient Account #
Category	Cost Reimbursement	Rendered
Exam	\$50	
Labs (Western Blot)	\$50	
As the medical personnel authorized by KRS 216B.400 to perform sexual assault exams, I certify completion of the above checked categories		
Printed Name		Signature
Facility (Payee) Address	Phone #	Federal ID #

Medication: Patient Account #		
Category	Cost Reimbursement	Rendered
21-day meds	\$600	
I certify completion of the above checked category.		
Printed Name		Signature
Facility (Payee) Address	Phone #	Federal ID #

KRS49.490 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 the health department, the sexual assault nurse examiner, the victim's insurance carrier, or the Commonwealth.

I authorize the release of this information to the KY Claims Commission for billing purposes.	
_____	_____
Patient Signature	Date

