Kentucky Claims Commission / Kentucky Crime Victim Compensation
130 Brighton Park Blvd., Frankfort, KY 40601

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

Patient name: _____

Phone number: _____

To be entered by CVCB
CVCB 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 Crime Victims Compensation: (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 #

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 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 Crime Compensation for billing purposes.

_____

Patient Signature Date