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

HIV POST-EXPOSURE *THIRD* FOLLOW-UP EXAM / TREATMENT BILLING FORM

To be entered by CVCB

CVCB case # _____

Patient Name: _____

Attention authorized medical personnel administering treatment or service: check box for each service rendered.
Fax completed forms and <u>itemized bills</u> to (502) 573-4817. For information, call (502) 782-8255 / (800) 469-2120

Third / Final Follow-up Exam (Day 28)

Category	Cost Reimbursement	Rendered
Exam	$50	
Labs CBC, CMP)	$75	

I certify completion of the above checked categories.

_____
Printed Name Signature

_____
Facility (Payee) Address Phone # Federal ID #

KRS 346.200(9) <u>No charge shall be made to the victim for sexual assault examinations</u> by the hospital, the sexual assault examination facility, the physician, the pharmacist or health department, the sexual assault nurse examiner, the victim's insurance carrier, or the Commonwealth.

I authorize the release of this information to KY Crime Victim Compensation for billing purposes.

_____ _____
Patient Signature Date