# Sexual Assault Examination Program
# Reimbursement Form
## Crime Victims Compensation Program

**VICTIM INFORMATION**

Victimôs Name: _____ SSN:_____-____-_____

Victimôs Address: _____ City: _____ State: _____ Zip: _____

Victimôs Date of Birth: _____ Gender: ☐ Male ☐ Female Telephone #: (____)_____

Legal Guardian (if victim is a minor): _____ Relationship: _____

Address (if different from Victim): _____

**Do you have insurance**? ☐ Yes ☐ No

Insurance Company: _____ Policy #: _____

**Crime Type:** ☐ **Adult Sexual Assault** ☐ **Adult Rape** ☐ **Minor Sexual Abuse**

Date of crime: _____ Location of Crime (City/State): _____

Was a law enforcement report filed under the victimôs name? ☐ Yes ☐ No

Law Enforcement Agency: _____ Report #: _____

I authorize the facility listed below to bill my private insurance or any other source of benefit available to me for the examination. I further authorize my billing information and medical records relating to this examination to be released to the Crime Victims Compensation Program for payment consideration and to the prosecutorôs office for the purposes of securing restitution.

_____ _____

Victimôs Signature (Legal Guardian, if victim is a minor) Date

**MEDICAL FACILITY INFORMATION**

Anonymous Report: ☐ Yes ☐ No

Name of Medical Facility:_____ Date of Service:_____

Address: _____ City: _____ State: _____ Zip:_____

Contact Person:_____ Telephone Number: (____)_____

A copy of the itemized billing, insurance explanation of benefits (EOB), medical records, and the reimbursement form, must be submitted within one year of the examination. All other payment sources available to the victim must make payment prior to the program making payment on behalf of the victim. Submit to:

**Crime Victims Compensation Program**
**P. O. Box 83720**
**Boise, Idaho 83720-0041**
**(208) 334-6080 or (800) 950-2110**

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