

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

**VICTIM INFORMATION**

Victim's Name: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Victim's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Victim's 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 victim's 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 prosecutor's office for the purposes of securing restitution.

Victim's 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**