Sexual Assault Forensic Examination Reimbursement

Idaho Crime Victims Compensation Program

VICTIM INFORMATION

Victim's Name: ______________________ SSN: ____ - ____ - ____

Victim's Address: ______________ City: ____________ State: ____ Zip: ____

Victim's Date of Birth: ___/___/_____ (MM DD YYYY) Gender: ☐ Male ☐ Female Phone #: (   ) ________

Legal Guardian: ______________________

Relationship: ______________ Email Address: ______________

Address (if different from Victim): ______________________

AUTHORIZATION TO RELEASE INFORMATION

I authorize my insurance information, billing information and all medical records or reports 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.

xxx______________________________ ______________

Signature of Victim or Legal Guardian (Parent/Legal Guardian if victim is a minor) Date

CRIME INFORMATION

Crime Type: ☐ **Adult Sexual Assault** ☐ **Minor Sexual Abuse** Date of Examination: ___/___/_____ (MM DD YYYY)

Date of crime: ___/___/_____ (MM DD YYYY) Location of Crime (City, State): ______________

LAW ENFORCEMENT INFORMATION

Was a law enforcement report filed under the victim's name? ☐ Yes ☐ No

If so, Law Enforcement Agency: ______________ Report #: ____________

Name of Person Who Committed Crime (Optional): ______________

MEDICAL FACILITY INFORMATION

Medical Facility where Examination was Completed: ______________

Address: ______________ City: ____________ State: ____ Zip: ____

SANE Nurse: ______________ Phone #: (   ) ________ **S.A. Kit #:** ________

ADULT VICTIMS (check all that apply)	MINOR VICTIMS (check all that apply)
☐ Medicaid ____________	☐ Medicaid ____________
☐ Medicare ____________	☐ Insurance Co. ____________
☐ VA Benefits ____________	Policy # ____________

Patient should not be billed for Sexual Assault Exam.

Required billing documentation located at: https://crimevictimcomp.idaho.gov/sexual-assault-forensics-examinations/

Submit Claims To: Crime Victims Compensation Program
P. O. Box 83720, Boise, Idaho 83720-0041
For Questions Call: (208) 334-6080 or (800) 950-2110

Revised 10/2020