



SAFE (SEXUAL ASSAULT FORENSIC EXAM PAYMENT PROGRAM) REQUEST FOR PAYMENT FORM

SECTION 1- FORENSIC EXAM

A. Exam Type (please select one):

ACUTE: I utilized Physical Evidence Recovery Kit (PERK) number _____ and released it to:
 Law Enforcement DCLS Other
 Is this a restricted or unreported crime? (PERK exams only) Yes No
 Note: A head-to-toe patient exam is necessary for SAFE reimbursement.

NON-ACUTE: No PERK was used.
 Note: A head-to-toe patient exam is necessary for SAFE reimbursement.

FOLLOW-UP: Initial Date of Service: _____

Name/Title of authorizing law enforcement, if applicable (authorization not required)

B. Forensic Nurse Examiner Information

Forensic Examiner Name (please print)

Forensic Examiner Phone No.

FNE Signature

Facility Name

Facility Billing Address

Billing Contact Name

Billing Contact Email Address

Billing Contact Phone No.

SECTION 2- PATIENT INFORMATION

A. Patient Information:

Patient First Name

Patient MI

Patient Last Name

Patient Date of Birth

Patient Social Security No.

Patient Gender

I have attached a patient label to this form in lieu of completing the patient information section. **(Billing information must still be completed.)**

B. Billing Method (please select one):

Patient is covered by a federally funded insurance and would like SAFE to pay any out-of-pocket patient balance remaining.
 Medicaid Medicare Tricare

Patient would like the provider to bill their private health insurance and would like SAFE to pay any out-of-pocket patient balance remaining.

Patient asks SAFE to pay all eligible examination related expenses.

SECTION 3- INCIDENT/EXAM INFORMATION

Date/Time of Crime (if unknown, use first day of exam month)

Crime Location- City/County (required)

Date/Time of Exam

Investigating Agency (or say "unreported" if this is an unreported crime)