VIRGINIA VICTIMS FUND
Helping Innocent Victims of Crime
OFFICIALLY CRIMINAL INJURIES COMPENSATION FUND
virginiavictimsfund.org

Shannon Dion
Director

A Division of the Virginia Workers' Compensation Commission

Email: safe@virginiavictimsfund.org · Mail: P.O. Box 26927, Richmond, Virginia 23261 · Phone: 800.552.4007 · SAFE Fax: 804.823.6907

SAFE (Sexual Assault Forensic Exam) Payment Program
Request for Payment Form

Section 1 – Forensic Exam

A. Exam Type (please select one):

☐ I utilized Physical Evidence Recovery Kit (PERK) number ________________ and released it to: ☐ the law enforcement ☐ DCLS or ☐ other_________________ **Is this a restricted or unreported crime? (PERK exams only).** ☐ **Yes**

☐ I did not use a PERK and the exam was authorized by the following law-enforcement official or prosecutor.
Name/Title (**required**): ____

☐ I performed a follow-up exam to forensically document the healing of injuries and/or differentiate initial findings that was requested and authorized by the following law-enforcement official or prosecutor.
Name/Title (required): ____________________________________ Initial Date of service: ________________

____ ________________________________
Forensic Examiner Name/Title/Phone Number Signature

____
Facility Name/Billing Address

____ ________________________________
Billing Contact Person Name and Email Address Phone Number

Section 2 - Patient Information

____
Patient Name – First, Middle Initial, Last

Affix Patient Label Here

____________________ ______________ ____________
DOB Last 4 SSN Sex

Billing Method (please select one):

Patient is covered by a **federally-funded insurance** (Medicaid, Medicare, Tricare, Veterans' Administration, etc.), **which MUST be billed first,** and would like the SAFE Payment Program to pay any out-of-pocket patient balance remaining. Please list insurance provider: ______________________________

Patient wishes for the provider to bill his/her **private health insurance** and would like the SAFE Payment Program to pay any out-of-pocket patient balance remaining.

Patient wishes for the **SAFE Payment Program** to pay for all eligible examination-related expenses.

Section 3 - Incident/Exam Information

____ ____
Date/Time of Crime (if unknown, please estimate if possible) Crime location (City/County – unknown is not acceptable)

____ ____
Date/Time of Exam Investigating Agency