THE COMMONWEALTH OF MASSACHUSETTS
OFFICE OF THE ATTORNEY GENERAL
VICTIM COMPENSATION AND ASSISTANCE DIVISION
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ATTACHMENT B

Forensic Sexual Assault Medical Examination Contact Form

SECTION 1. VICTIM INFORMATION

Name:_____

Address:_____

Date of Birth:_____ Date of incident:_____

Kit #:_____ Date that the Kit was administered:_____

Town/City/State where this assault occurred:_____
(Note: If assault occurred in another state, the Attorney General's Victim Compensation and Assistance Division *cannot provide payment. Please contact the Division for information concerning the state compensation program that can assist with these expenses.)*

SECTION 2. PROVIDER INFORMATION

Name of Treating Hospital:_____

Name of hospital contact submitting claim: _____

Email: _____ Tel: _____

By submitting this information, the hospital affirms that this request for payment of a forensic medical examination are for services that were provided to the patient and are eligible for payment as described in the Protocol and Billing Procedures as described in the Memorandum related to Coverage for Forensic Medical Examinations in Cases of Sexual Assault. Hospital further accepts responsibility for the accuracy in the services provided and the requested coverage for the forensic medical examination costs.