

**Sexual Assault Forensic Examination Program  
Fast Track Reimbursement Form  
Utah Office for Victims of Crime**

Victim Name: \_\_\_\_\_

Victim Date of Birth: \_\_\_\_\_

Victim Address: \_\_\_\_\_

Victim Telephone Number: \_\_\_\_\_

Victim Medical Insurance Provider: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Law Enforcement Agency: \_\_\_\_\_

Law Enforcement Case Number: \_\_\_\_\_

Date of Service: \_\_\_\_\_

Service Provider Name and Address: \_\_\_\_\_

\_\_\_\_\_

**A copy of the itemized billing including current procedural codes, along with this form, must be submitted within one year of the examination. Please consider all other collateral sources before submitting a request for payment to UOVC. The director can make exceptions in extenuating circumstance cases. Submit to:**

Utah Office for Victims of Crime  
350 East 500 South Suite 200  
Salt Lake City, Utah 84111  
Fax: (801)533-4127  
Email: [crimevictims@utah.gov](mailto:crimevictims@utah.gov)

**PLEASE NOTE:**

**Reimbursement can be made only if the Sexual Assault Examination was reported to law enforcement. Please make every effort to provide the law enforcement case number. This form must be signed by the law enforcement officer, a victim/witness coordinator or the medical provider if the law enforcement case number is not available.**

I hereby certify that the above-named victim received a sexual assault forensic examination performed by the provider listed above.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Title: \_\_\_\_\_