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IOWA DEPARTMENT OF JUSTICE
OFFICE OF THE ATTORNEY GENERAL
VICTIM ASSISTANCE SECTION

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**Sexual Assault Examination Program
Qualified Provider Reimbursement Invoice**

Date & Time of Service: _____ Date of Assault: _____

Account/Invoice #: _____ Invoice Date: _____

If SANE: Use last 4 digits of SSN, Date and 1,2,3 etc.
If other medical provider: Use Clinic Account Number

Initial Exam
 Acute Follow-up
Follow-Up Care

CPC Use Only
 Disclosed sexual abuse to CPC on date: _____
 No disclosure, but suspected SA

Patient Name: _____ Date of Birth: _____ Female Male

Was an evidence kit collected: Yes No If Yes, provide barcode number: _____

If no evidence kit collected: Declined Unable to Consent >5 days from assault or >3 days (pediatric)
 Current Medical Condition does not allow Other: _____

Medications prescribed: Yes No Pharmacy Name: _____

Location of Exam (Facility Name/Address): _____

Effective December 18, 2024, Qualified Providers are eligible to receive \$400 per exam. Below please list all treatment provided to the victim and the amount you are billing to the Sexual Assault Examination Program.

Treatment provided: _____ **Amount billed to the SAE Program:** _____

Treatment was provided by: _____, who is a Qualified Provider.

Did the Qualified Provider travel to perform treatment? Yes No

Payment for the treatment should be paid to: Facility Qualified Provider Telehealth

Address where payment should be sent: _____

Payable Tax ID or SSN: _____ Phone #: _____ Email: _____

*If a sexual abuse evidence collection kit was offered, a copy of the patient's completed consent form created by the Iowa Department of Justice must accompany this invoice. Iowa Code section 709.10(11), IAC61-9.83(2).
*If a sexual abuse evidence kit was collected it must be entered in the Track-Kit system *before a qualified provider's payment can be issued.* Iowa Code section 915.41 (2).

By signing this form, I hereby certify I am the Qualified Provider of this patient or a representative on behalf of the Qualified Provider, with the authority to bill for these services:

Signature of Qualified Provider or Representative _____ Printed Name _____ Date _____

Submit form via fax 515-281-8199, email to SAE@ag.iowa.gov, or address above.