REQUEST FOR PAYMENT FROM
THE WISCONSIN DEPARTMENT OF JUSTICE

WI SAFE Fund

(Sexual Assault Forensic Exam)

ATTACH THIS FORM TO AN ITEMIZED COPY OF EACH BILL
Report pursuant to Wis. Stat. §949.24(3)

Information can be mailed, faxed, or emailed as follows:

Mail to: Wisconsin Department of Justice
SAFE Fund, ATTN: Terri Wixom
PO Box 7951
Madison, WI 53707-7951

Fax to: 608-294-2928
Email: wixomta@doj.state.wi.us

Date: _____

Name of Patient: _____

Date of Assault: _____ **Location (City, State of Assault):** _____

EXAMINING PROVIDER: I verify that a sexual assault forensic examination has been performed for this victim to gather evidence regarding a sex offense, and that may include tests for or that prevents a sexually transmitted disease, and provision or prescription for any medication to prevent or treat a sexually transmitted disease.		
FACILITY NAME	FACILITY ADDRESS	
MEDICAL PROVIDER NAME AND TITLE	COUNTY OF FACILITY	PHONE NUMBER
FEDERAL TAX ID NUMBER		
SIGNATURE OF MEDICAL PROVIDER *	SIGNATURE OF CO-EXAMINER (IF APPLICABLE)	

***Must be signed by treating/examining physician, physician's assistant, or nurse**

Billing Contact Person Name & Telephone Number: _____

Reason for SAFE Fund Payment:

- ☐ Did not wish to report to law enforcement
- ☐ Did not wish to cooperate with law enforcement
- ☐ Did not wish to submit bill to insurance provider
- ☐ Did not wish to submit bill or any portion of bill to other available payer source (i.e. patient, guarantor, guardian, etc.)
- ☐ Patient and/or guardian does not have insurance

If you have any questions, please contact Terri Wixom at WixomTA@doj.state.wi.us.

- NOTE: Insurance can be billed only with patient's consent. If insurance has paid any portion of the forensic exam, you must attach the EOB in order for the bill or any remaining balance to be considered for reimbursement by the SAFE Fund. A health care provider seeking an award may not seek payment for any sexual assault forensic examination costs from the victim or any guardian of the victim.