# Medical Evidentiary Examination Reimbursement Invoice

**Submission Date:**

**Law Enforcement Agency Name:**

**Payment Address:**

**Contact Person Name:**

**Contact Person Phone Number:**

**Contact Person Email:**

**Bill To:** California Governor’s Office of Emergency Services

3650 Schriever Avenue, Mather, CA 95655

Exams for **victims that are undecided**, at the time of an examination, whether to report the assault to law enforcement.

|  |  |  |  |
| --- | --- | --- | --- |
| **Date of Examination** | **Case #** | **Actual Cost of Exam** | **Reimbursement Requested (no****more than $911 per examination)** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **Total Requested** | $ 0.00 |

Exams for **victims that have determined**, at the time of the examination, to report the assault to law enforcement. This includes examinations for all children under the age of 12.

|  |  |  |  |
| --- | --- | --- | --- |
| **Date of Examination** | **Case #** | **Actual Cost of Exam** | **Reimbursement Requested (no more than $1,127 per examination)** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **Total Requested** | $ 0.00 |

|  |
| --- |
| **Cal OES Use Only - Authority to Pay: Penal Code §13823.95** |
| Undecided Amount | Undecided Service Location | Decided Amount | Decided Service Location |
|  |  |  |  |