HIV PROPHYLAXIS REIMBURSEMENT REQUEST FORM

Ohio Attorney General Sexual Assault Forensic Examination (SAFE) Program

PLEASE ANSWER ALL QUESTIONS

1. Medical Facility
Do not fill out this field. It will populate with the SAFE form.
Address
City

2. SAFE Account (Vendor ID No.)
Do not fill out this field

3. Patient Name:

4. Did patient have a SAFE conducted at time of HIV Risk Assessment?:
☐ Yes ☐ No

5. Patient Medical Record Number:

6. Date When Treatment Started:
☐☐/☐☐/☐☐☐☐

7. Was patient under the age of 18? ☐ Yes ☐ No

8. Was the patient assessed for exposure to HIV Risk? ☐ Yes ☐ No

9. If yes, was patient determined at risk per the CDC HIV Risk assessment? ☐ Yes ☐ No

10. If yes, was a HIV Rapid Screen completed? ☐ Yes ☐ No If no, why?

What was the result?

11. If patient screened negative on HIV Rapid Screen, was patient given the 28-day HIV nPEP regimen prior to the patients release from the medical facility? (28 day required for SAFE reimbursement)
☐ Yes ☐ No

If not, why?

Please include costs on invoice incurred by the patient for labs, pregnancy testing, rapid HIV test, prophylaxis, and anti-emetic medication (see instructions for specific charges related to HIV exposure assessment).

What are the total costs requested this billing cycle for the HIV Prophylaxis protocol? _____

12. Where was the patient referred for follow-up services?

Agency:

City:

County:

13. Along with the submission of the Reimbursement Request Form, attach a pdf itemized statement reflecting actual costs of medications and services rendered (see instructions).

By sending this electronic transmission, I solemnly affirm that I am duly authorized to make this submission on behalf of the above noted medical facility, and that all information included herein is true and accurate to the best of my knowledge and belief.

14. Submit as a saved pdf document along with the SAFE itemized bill.	For Questions about Billing, Please Call: (614) 466-4797