SUPPLEMENTAL HIV PROPHYLAXIS REIMBURSEMENT REQUEST FORM

Ohio Attorney General Sexual Assault Forensic Examination (SAFE) Program

PLEASE ANSWER ALL QUESTIONS

1. Medical Facility:	2. SAFE Account (Vendor ID No.):
3. Patient Name:	
4.Treatment Date for Reimbursement: ☐☐/☐☐/☐☐☐☐ Services provided on this date (note all services for reimbursement reflected on the attached invoice): What are the total costs requested this billing cycle for the HIV Prophylaxis protocol? _____	5. Patient Medical Record Number: 6. First Treatment Date: ☐☐/☐☐/☐☐☐☐

7. 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.

Submit To: safe@ohioattorneygeneral.gov	For Questions about Billing, Please Call: (614) 466-4797