Maryland
GOVERNOR'S OFFICE OF CRIME PREVENTION AND POLICY

Sexual Assault Reimbursement Unit (SARU)

nPEP/HIV Prophylaxis Pharmacy Reimbursement Form

Please email this completed form or any questions about claims and payment processes to saru.claims@maryland.gov.

Date of Service:

Patient Information

Name:

(Last) (First) (Middle)

DOB:

Is the patient younger than 18 years old?

If you answered yes, in accordance with Maryland law, please contact the local Department of Social Services (DSS) or local law enforcement for the jurisdiction where you believe the incident(s) occurred.

Maryland law also provides that a healthcare provider who treats a child victim of sexual abuse is immune from civil liability that may result from treating the child without consent from the child's parent, guardian, or custodian.

Insurance

Did you advise the patient of their right to provide or decline to provide their insurance or benefits information?

Did the patient provide insurance or benefits information?

Maryland law states that a victim of an alleged rape or sexual offense or a victim of alleged child sexual abuse who declines to provide health insurance or other benefits information is entitled to receive treatment and follow-up care at no cost.

Patient Resources

Did you provide information about hospital-based FNE programs where the patient can access additional services free of charge, including a sexual assault evidence exam, treatment, and nPEP follow-up care?

Was a follow-up care referral made?

Referral Location:

Prescription Information

Prescription #:

Medication Prescribed:
(Include anti-nausea or other medication provided to mitigate side effects)

Invoice No.:

Number of days/doses of nPEP provided:

Pharmacy Information

Pharmacy Name:

Billing Address:

Federal Tax ID:

Phone:

Pharmacist Information

Dispensing Pharmacist Name:

License #:

Pharmacist Signature:

Certification of Sexual Assault Treatment to Validate Reimbursement

I hereby attest and affirm that _____ (Patient's full name) requested and received a full course of treatment for postexposure prophylaxis for the prevention of HIV infection. I attest and affirm that to the best of my knowledge, the patient requested treatment because of potential HIV exposure arising from an alleged rape, sexual assault, or child sexual abuse in accordance with COMAR 10.12.02.5. I certify that any items billed to the SARU for reimbursement are for the treatment of alleged **rape, sexual assault, or child sexual abuse**.

Pharmacist Signature:

Date: