RHODE ISLAND DEPARTMENT OF HEALTH
TITLE X FAMILY PLANNING PROJECT
HIV CTR PROJECT
Date of Service after July 1st 2008 for STANDARD HIV TESTING

CONTRACTOR REQUEST FOR PAYMENT

VENDOR _____

_____

_____

REIMBURSEMENT FOR SERVICES RENDERED: HIV Counseling, Testing, & Referral

BILLING PERIOD _____ TO _____

EXPENSE CATEGORY	TOTAL NUMBER OF FORMS	AMOUNT
Stardard Testing for Uninsured @$30.00		
Stardard Testing for Insured @$10.00		
TOTAL		$0.00

SIGNATURE FOR AGENCY _____ DATE _____

Processed: _____
PK

Data Entry Received Date: _____

Data Entry Completed Date: _____