



STATE OF KANSAS
OFFICE OF THE ATTORNEY GENERAL

DEREK SCHMIDT
ATTORNEY GENERAL

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**AUTOPSY REIMBURSEMENT
BILLING FORM**

Date of Invoice: _____ Invoice #: _____ County: _____

Name of Child: _____ Date of Death: _____

Cause of Death: _____ Manner of Death: _____

Coroner: _____ Coroner Case #: _____

Date of Service: _____ Federal Tax ID #: _____

Professional Autopsy Fees.....	\$ _____
Facility Fees.....	\$ _____
Radiology Fees.....	\$ _____
Toxicology Fees.....	\$ _____
Laboratory Fees.....	\$ _____
Hospital Lab/Slide Fees.....	\$ _____
Body Transport Fees.....	\$ _____
Body Storage Fees.....	\$ _____
Body Bag(s)	\$ _____
Technician Fees.....	\$ _____
TOTAL DUE: \$ _____	

REMIT PAYMENT TO:
(Agency)
(ATTN:)
(Address 1)
(Address 2)
(Address 3)