eXPRS Plan of Care – Mileage Driven Report Form

Customer Name: ____ Prime: __________________________

Provider Name: ____ Provider Num: __________________

CM Organization: _________________________________ SC/PA Name: ________________________________

Service: **OR004: Service Related Community Transportation - Mileage** Mod Cd: _____ Units: _______ Type: **MILES** Freq: _______

Service Delivered On:

Date	**Total Miles for Date**	**Group?** (yes / no)	**Purpose of Trip/Service Goal** ***** this information is required - write in, as needed***

TOTAL MILES

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Provider Name: ____ Provider Num: ________________

CM Organization: ______________________________ SC/PA Name: _____________________________

SERVICE GOAL:

PROGRESS NOTES (attach additional pages, if needed):

RECIPIENT/EMPLOYER VERIFICATION:

I affirm that the data reported on this form is for actual dates/time worked by the provider delivering the service/supports listed to the recipient, that it does not exceed the total amount of service authorized and was delivered according to the recipient's service plan and provider/recipient service agreement.

____

Customer Employer or Employer Rep Signature Date

PROVIDER/EMPLOYEE VERIFICATION:

I affirm that the data reported on this form is for actual dates/time I worked delivering the service/supports listed to the recipient, that it does not exceed the total amount of service authorized and was delivered according to the recipient's service plan and provider/recipient service agreement. I further acknowledge that reporting dates/time worked in excess of the amount of service authorized or not consistent with the recipient's service plan nay be considered Medicaid Fraud.

____

Provider/Employee Signature Date

[ ] I authorize CDDP/Brokerage/CIIS staff to enter the data reported on this from into eXPRS on my behalf for claims creation and payment. __________ (provider initials).

CDDP/BROKERAGE/CIIS STAFF REVIEW:

This service delivery report has been reviewed and is consistent with the recipient's service plan and authorized service limits.

____

CDDP/Brokerage/CIIS Staff Signature Date

Providers submit this completed/signed form to the CDDP, Brokerage or CIIS Program that authorized the service delivered.