eXPRS Plan of Care - Services Delivered Report Form

Customer Name: ______________________________ Prime: ________________

Provider Name: ______________________________ Provider #: ________________

CM Organization: ______________________________ SC/PA Name: ________________

Service Authorized: ____________ Mod Cd: _____ Units: ______ Type: _______ Freq: _______

Service Delivered On:

Date	Start/Time IN	End/Time OUT	Total Service Units/Hours for Entry	Group? (yes / no)
	AM PM	AM PM		
	AM PM	AM PM		
	AM PM	AM PM		
	AM PM	AM PM		
	AM PM	AM PM		
	AM PM	AM PM		
	AM PM	AM PM		
	AM PM	AM PM		
	AM PM	AM PM		
	AM PM	AM PM		
	AM PM	AM PM		
	AM PM	AM PM		
	AM PM	AM PM		
	AM PM	AM PM		
	AM PM	AM PM		
	AM PM	AM PM		
	AM PM	AM PM		
	AM PM	AM PM		
	AM PM	AM PM		
	AM PM	AM PM		
	AM PM	AM PM		
	AM PM	AM PM		
	AM PM	AM PM		
	AM PM	AM PM		
		TOTAL UNITS/HOURS		

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Customer Name: _____ Prime: _____

Provider Name: _____ Provider #: _____

CM Organization: _____ SC/PA Name: _____

SERVICE GOAL:

PROGRESS NOTES (attach additional pages, as 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 for the recipient 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 by the 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 I worked in excess of the amount of service authorized for me or not consistent with the recipient's service plan may 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.