eXPRS Plan of Care – Mileage Driven Report Form

Customer Name: _____________________________________ Prime: ________________________
Provider Name: _____________________________________ Provider Num: _________________
CM Organization: ___________________________________ SC/PA Name: ____________________

Service: OR004: Service Related Mod Cd: _____ Units: ______ Type: MILES Freq: ______

Community Transportation - Mileage

Service Delivered On:

<table>
<thead>
<tr>
<th>Date</th>
<th>Total Miles for Date</th>
<th>Group? (yes / no)</th>
<th>Purpose of Trip/Service Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>** this information is required - write in, as needed</td>
</tr>
</tbody>
</table>

TOTAL MILES

POC Mileage driven rpt form STNDRD (v13; 10-5-15).doc
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eXPRS Plan of Care – Mileage Driven Report

Customer Name: ________________________________  Prime: ______________________________

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 may be considered Medicaid Fraud.

___________________________________________________  __________________________________________
Provider/Employee Signature         Date

[   ]  I authorize CDDP/Brokerage/CIIS staff to enter the data reported on this form 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.