

eXPRS Plan of Care - Services Delivered Report Form

Customer Name: _____ Prime: _____ Month: _____ Year: _____

Provider Name: _____ Provider #: _____

CDDP/Brokerage: _____ 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 staff to enter the data reported on this form into eXPRS on my behalf for claims creation and payment. _____ (provider initials).

CDDP/BROKERAGE REVIEW:

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

CDDP/Brokerage Rep Signature

Date

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