eXPRS Plan of Care – Mileage Driven Report Form

Client Name: _____ Prime: _____ Month: _____ Year: ____

Provider Name: _____ Provider Num: _____

CDDP/Brokerage: _____SC/PA Name: _____

Service: **OR004: Service Related Community Transportation - Mileage** Units: ____ Type: **MILES** Freq: _____

Service Delivered On:

Date	Total Miles	# of Clients	Purpose of Trip/Service Goal

eXPRS Plan of Care - Mileage Report

Client Name: _____ Prime: _____ Month: _____ Year: ____

Provider Name: _____ Provider Num: _____

CDDP/Brokerage: _____ SC/PA Name: _____

SERVICE GOAL:

PROGRESS NOTES:

By signing below, both employer and provider affirm that the mileage driven and supports provided as reported above do not exceed the amount authorized in the service recipient's Plan of Care and are consistent with the services to be delivered as outlined in the provider's service agreement with the recipient.

_____

Service Recipient/Employer/Employer Rep Signature Date

_____

Provider/Employee Signature Date

[ ] I authorize the state to enter the above service delivery data into eXPRS on my behalf for claims creation and payment based upon this service delivery report.

_____ (provider initials).

[ ] This service delivery report has been reviewed/approved for claim(s) creation.

_____

CDDP/Brokerage Rep Signature Date

For state staff entry of data for claim creation on behalf of provider, submit this completed/signed/approved form to:

Email: info.exprs@state.or.us or **Fax**: 503-947-5004