Express Payment & Reporting System

Customer Name:

Prime:

Provider Name:

Provider Num:

CM Organization: EASTERN OR SUPPORT SVCS BROKERAGE /Case Mgmt Prov

SC/PA Name:

Service: SE149 / OR526 - Attendant Care, home or comm / NA - Not Applicable

Service Delivered On:

Date	Start/Time IN	End/Time OUT	Total 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 HOURS

Customer Name: **Prime:**

Provider Name: **Provider Num:**

CM Organization: EASTERN OR SUPPORT SVCS BROKERAGE /Case Mgmt Prov **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.

_____ Date: _____

Customer Employer or Employer Rep Signature

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.

_____ Date: _____

Provider/Employee Signature

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

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

Oregon Department of Human Services
Express Payment & Reporting System (eXPRS)

eXPRS
Express Payment & Reporting System

eXPRS Plan of Care - Mileage Driven Form

Customer Name:

Prime:

Provider Name:

Provider Num:

CM Organization: EASTERN OR SUPPORT SVCS BROKERAGE /Case Mgmt Prov

SC/PA Name:

Service: SE149 / OR004 - Comm Transp, Mileage / WE - Community

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

Customer Name:

Prime:

Provider Name:

Provider Num:

CM Organization: EASTERN OR SUPPORT SVCS BROKERAGE /Case Mgmt Prov

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

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

Oregon Department of Human Services
Express Payment & Reporting System (eXPRS)

eXPRS Plan of Care - Services Delivered Form