



# The Arc Central Chesapeake Region Self-Directed Services Mileage Reimbursement

EMAIL: FMSMileage@thearcccr.org

FMS FAX: 410.269.0034 FMS PHONE: 410.269.1883

Please check if this is a CORRECTED form. Please refer to the Accounts Payable calendar for submittal due dates.

EMPLOYEE NAME (please print):	Month:	Year:
-------------------------------	--------	-------

EMPLOYER NAME (please print):	DEPT #:
-------------------------------	---------

Date	Destination	Purpose	Miles
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			
26			
27			
28			
29			
30			
31			

BY SIGNING BELOW, I CERTIFY THAT THE SERVICES REFLECTED ARE TRUE AND ACCURATE AND THAT THE SERVICES ARE IN ACCORDANCE WITH MARYLAND DDA STANDARDS. FALSE INFORMATION CONSTITUTES MEDICAID FRAUD.	Total Miles Driven
	Reimbursement Rate
	Reimbursement Request Amount

EMPLOYEE SIGNATURE:	DATE:
---------------------	-------

EMPLOYER/DESIGNATED REP SIGNATURE:	DATE:
------------------------------------	-------

**PLEASE NOTE THE FOLLOWING PROCESSING CRITERIA FOR MILEAGE REIMBURSEMENT:**

\* Transportation provided to medical appointments or out of state must be approved in the plan.

\* Mileage reimbursement to non-employees is by DDA approval only \* Reimbursement rates are not to exceed plan approved rates.

\* Federal mileage reimbursement rates do not impact plan approved rates. Please complete a modification to change rates.

\*\*\*\*\*PLEASE DO NOT WRITE BELOW THIS LINE\*\*\*\*\*

Service Code:	Amount:	Service Code:	Amount:
<input style="width:90%" type="text"/>	<input style="width:90%" type="text"/>	<input style="width:90%" type="text"/>	<input style="width:90%" type="text"/>

- NPP
- NPP