The Arc Central Chesapeake Region
Self-Directed Services Mileage Reimbursement

The Arc
Central Chesapeake Region

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☐ 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			
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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:	

☐ **NPP**
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