**Section 1 - Participant Information & Approved Expenses:: *to be completed by UPCAP Care Manager***

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Participant Name | | | | | | | | | | | | | Ph# | | | | | | | | | | | Apt# |
| Street Address | | | | | | | | | | | | | **City** | | | | | | | **State** | | | | **Zip** |
| Directions to Home /Special Instns / Appt. Date & Time: | | | | | | | | | | | | | | | | | | | | | | | | |
| Per-Mile Rate: | | **\_\_** | Fed. Rate @ **.54 }** / | | | **\_\_** | Sppts Rate @ **.18 }** / | | **\_\_** | | Attendant @ **$15** / | | | **#** | | | | Overnight Stays - **$75** max w/receipt | | | | | | |
| Approved Meals: | | | | **#** | Breakfasts @ $8.50 / | | | **#** | Lunches @ $8.50 / | | | | | | | | | | **#** | | Dinners @ $19.00 | | | |
| Section 2 – Medical Provider Information: *to be completed by UPCAP Care Manager* | | | | | | | | | | | | | | | | | | | | | | | | |
| Medical Provider Name | | | | | | | | | | | | | | | | | Provider Ph# | | | | | | | |
| Provider Street Address | | | | | | | | | | | | | | | | | | | | | | | | |
| City | | | | | | | | | | **State** | | | | | | | | | | | | | **Zip** | |
| \_\_ | **🡸** Check if **One-Time Appointment /** | | | | | | | | | \_\_ | | **🡸** Check if **Ongoing Appointments 🡳** | | | | | | | | | | | | |
|  | **For ongoing appointments, indicate** (monthly, weekly, bi-wkly, 3X per wk, etc.): | | | | | | | | | | | | | | | (frequency) | | | | | | | | |
| Section 3 – Medical Transportation Information: *to be completed by Transportation Provider* | | | | | | | | | | | | | | | | | | | | | | | | |
| Transportation Provider Name | | | | | | | | | | | | | | | **Ph#** | | | | | | | | | |
| Mailing Address | | | | | | | | | | | | | | | **Attn:** | | | | | | | | | |
| City | | | | | | | | | **State** | | | | | | | | | | | | | **Zip** | | |

**🢃 Receipts Required** for **\* All Costs \***

**Section 4 – Reimbursement: *to be completed by Transportation Provider***

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Appt.  Date | Appt.  Time | Depart  Time | Return  Time | Medical Provider’s  Signature | Round  Trip Miles | Rate Per Mile | Trip Cost  (Miles x Rate) | | Lodging | Meal  Total | Other Costs | | Total |
| **Desc.** | **Amount** |
|  |  |  |  |  |  |  |  | |  |  |  |  |  |
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| Section 5 - Signatures / Attestations of Accuracy: | | | | | | | | **Grand Total:** $ | | | |  | |

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Participant Signature Date |  | **Transporter Signature Date** |
|  |  | *My signature certifies that I provided the above service(s) and did not receive any other payment for this transportation. I am not aware that the passenger received any other payment for this transport.* ***Sept18*** |
| Care Manager Signature Date |  |

**Reimbursement Form Instructions**

Use this form for **eight (8) or less trips** made in a calendar month.

Reimbursement Request forms must be submitted to UPCAP within **30 calendar days** from the last svc date.

**Return Completed Reimbursement Request to:**

UPCAP Contract Manager, PO Box 606, Escanaba, MI 49829 - Fax: (906) 786-5853

Reimbursements are processed one (1) time per month.

**Section I. - Participant Information & Approved Expenses:**

* **Care Managers** fill out the MI Choice Participant’s Info and Approved Services *(mileage, meals, lodging)*.
* Directions/Special Instructions used to specify what door to use, assistance needed, attendant, etc.

**Section 2. – Medical Provider Information:**

* **Care Managers** will complete this section - only one (1) Medical Provider per form.

**Section 3. – Medical Transportation Information:**

* **The Transportation Provider** completes this section.
* Use only one (1) Transporter per form.
* This section will be BLANK if the Participant drives themselves.

**Section 4. - Reimbursement for Driver (Volunteer, Participant, or Attendant)**

* Enter all approved dates, time, and expenses. Depart/return times are required for all trips.
* Has the **Medical Provider sign** EACH appointment line.

**Section 5. – Signatures / Attestations of Accuracy:**

* **All signatures** must be collected in order for Reimbursement to be issued.

**Meals -** *only when traveling out of the local area:*

* For Breakfast: The vehicle with the beneficiary must depart at, or before, 6:00 AM and must return at, or after 8:30 AM. / $8.50 (includes tax)
* For Lunch: The vehicle with the beneficiary must depart at, or before, 11:30 AM and must return at, or after, 2:00 PM. / $8.50 (includes tax)
* For Dinner: The vehicle with the beneficiary must depart at, or before, 6:30 PM and must return at, or after 8:00 PM. / $19.00 (includes tax)

**Lodging:** $75.00 max w/receipt (excludes tax)

**Other Approved Fees:** Actual

- **Approved Attendant** - *list under "Other Costs" column* $15

(Accompanies Participant into Appointment) Sept18