3289611459

Arizona Mercy Care Plan Program Time Sheet (AZ MC)

EMPLOYEE NAME (LAST NAME, FIRST NAME)

EMPLOYEE ID

MEMBER NAME (LAST NAME, FIRST NAME)

MEMBER ID

By signing this form, I attest that services were delivered and received consistent with the Service Plan/Authorization and I have rendered and/or approved this payment request in accordance with the Program regulations. I understand that payment and satisfaction of this claim may be from Federal and State funds, and that I may be prosecuted under applicable Federal or State laws for any false claims, statements, or documents, or concealment of a material fact. Any misuse of funds may result in being fined or penalized, including but not limited to the repayment of claim. Collection costs or legal fees will be my responsibility.

Employee Signature Date Employer Signature Date

SERVICE DATE MM/DD/YYYY	CHECK IN TIME	CHECK OUT TIME	SERVICE
/ /	: AM PM	: AM PM	
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Return toll-free by faxing WITHOUT COVERSHEET to (866) 708-3440 or mailing to Acumen at: 4542 E. Inverness Ave., Suite 210, Mesa, AZ 85206