MT SDEO Request for Payment or Reimbursement Form

1. Participant Name:	2. Participant Last 4 SSN:
Mary Participant	1111
3. Employer/Authorized Rep Name:	**4. Month/Year:**
Mom Participant	08/2021

5. Payment Instructions: (Mark One) This is a Reimbursement [X] This is a Vendor Payment [ ]

6. Make Check Payable To: Mom Participant	
7. Vendor Payment - Business/Agency FEIN or Reimbursement - Employer/Auth Rep SS#: 111-22-3333	**8. Business Name If different than #6:**
9. Address: 123 Mom Lane	**10. City/State/Zip:** Missoula, MT 59802

11.Invoice/ Service Date	**12.Service Code** (Listed on reverse)	**13. Description** (List all items for which you are requesting payment. ICP dollars cannot be used to purchase gift cards. W-9 must be on file prior to any vendor/business payment.)	**14. Total Amount**
07/20/yr	IGS	"Items must match what is on the invoice"	Total on Invoice
07/31/yr	SMES	"Items must match what is on the invoice"	Total on Invoice
		15.Total Check Amount	Line 1 + Line 2

REMINDER: Please attach a copy of the voided receipt or invoice.

By signing this form, I attest that services were delivered and received consistent with the Individual Service Plan and I have rendered and/or approved the above 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. I understand that Medicaid is the payer of last resort.

Authorized Representative's Signature Date **Case Manager's Signature Date**

Return completed form with copy of the receipt or invoice to 5416 E. Baseline Rd., Suite 200, Mesa, AZ 85206 or FAX to (866) 211-6370.

Service Code	0208 Comprehensive Waiver Service	Service Code	0208 Comprehensive Waiver Service
CST	Community Transition Services	PERS	Personal Emergency Response System
ENVM	Environmental Modifications	SMES	Specialized Medical Equipment and Supplies
IGS	Individual Goods and Services	SMS	Specialized Medical Supplies
MEAL	Meals	TRMO	Transportation Other (non-mileage)

- Please refer to the MT SDEO Enrollment Packet for information important to self-directing your services.

Requests for reimbursement or payment **cannot** be submitted until the goods or services have been provided. (E.g. A monthly or annual gym membership cannot be paid until after the month of service has passed. It is easiest to keep track of monthly reimbursements if you submit the invoice at the end of the year for a full reimbursement).

- Vendor (agency/business) payments – Payments cannot be requested until the service or goods have been provided. Acumen must have a W-9 on file prior to any payment to a vendor. A Vendor cannot be paid if their name shows up on the List of Excluded Individuals and Entities (LEIE) that is published by the Attorney General.
- Employer/Authorized Representative Reimbursement (reimbursement for goods and services that have been paid for) – Acumen must have a Social Security Number (SS#) on file prior to any reimbursement or payment made. A person cannot be paid if their name shows up on the List of Excluded Individuals and Entities (LEIE) that is published by the Attorney General.
- Gift Cards are NOT an allowable purchase in this program

Form Instructions for Authorized Reps/Employers

1. Participant Name: Person receiving funding through the waiver.
2. Participant last 4 of their Social Security Number
3. Employer/Authorized Rep Name: Person enrolled with Acumen as the employer or Authorized Representative.
4. Month/Year: Month and year form is completed
5. Payment Instructions: Mark if this request is a reimbursement payment to the Employer/Authorized Rep or a payment to a Vendor (agency business).
6. Make Check Payable to: Business name or individual name who is being paid/reimbursed.
7. Vendor Payment - FEIN or Reimbursement - SS#: The business or agency Federal Employer Identification Number on the W-9 or the Social Security Number for the person being reimbursed.
8. Business Name if different than: Enter name of business if different from the name entered in field # 6.
9. Address: Street address of Business/Agency or individual being reimbursed.
10. City/State/Zip: City, State, Zip code of Business/Agency or individual being reimbursed.
11. Invoice/Service Date: Date of service on the invoice, or date on invoice that goods were purchased.
12. Service Code: Use one of the service codes listed above that matches the service that was authorized.
13. Description: List all items or services you are submitting for payment/reimbursement.
14. Total amount for items listed on each line.
15. Check amount: The total of all items listed. This will be the total payment/reimbursement requested.
16. Both the Authorized Rep and Case Manager must sign the Request for Payment/Reimbursement form.
17. * Do not submit requests that go over the authorized amount. Acumen will NOT make a determination of what items to pay, or a partial pay of the request. The item can cost more than what is requested for reimbursement/payment.