Acumen Fiscal Agent
Innovation · Opportunity · Freedom

MT - Request for Payment or Reimbursement Form

1. Participant Name: Mary Participant	**2. Medicaid ID #:** 111111111
3. Employer/Authorized Rep Name: Mom Participant	**4. Month/Year:** 01/2026

5. Payment Instructions: (Check One) **This is a Reimbursement** ☑ **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 59804

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. Date Item(s) Received or Work Was Completed**	**15. Total Amount**
12/1/25	IGS	"Items must match what is on the invoice"	11/25/25	Total on Invoice
12/30/25	SMES	"Items must match what is on the invoice"	12/29/25	Total on Invoice
		15. Total Check Amount		Line 1+Line 2

REMINDER: Please attach a copy of the receipt or invoice. (A quote/bid is insufficient and will result in denial.)

By signing this form, I attest that services were <u>delivered and received</u> consistent with the Personal Support 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.

EMPLOYER SIGNATURE — **Authorized Representative's Signature**

1/1/2026 — **Date**

CM SIGNATURE — **Case Manager's Signature**

1/1/2026 — **Date**

Return completed form with a copy of the receipt or invoice to 5416 E. Baseline Rd., Suite 200, Mesa, AZ 85206; FAX to (866) 211-6370, or Email to enrollment-mt@Acumen2.net.

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

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/received. *(Example: A monthly or annual gym membership cannot be paid until after the month of service has passed. It is highly recommended to submit these types of invoices for reimbursement monthly or quarterly).*

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 appears 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.
- Receipts must show proof of purchase. (Quotes/bids are insufficient and will be denied.)
- 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. **Medicaid ID #:** Number provided by the state as a state Identifier. The Case Manager can provide this 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**: Check 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. **Date Item(s) Received or Work Was Completed:** Date that the listed items were received (IGS/SMES) or work was completed by Vendor (ENVM). ***Please note:*** *For online purchases, this will be the date the items were delivered to the participant, not the date of purchase.*
15. **Total amount**: Total amount for items listed on each line.
16. **Check amount:** The total amount for all items listed. This will be the total payment/reimbursement requested.
17. **Both the Authorized Rep and Case Manager must sign the Request for Payment/Reimbursement form.**