9585506783

Pennsylvania Mileage Reimbursement
Participant Directed Services Program

ACUMEN

EMPLOYEE NAME (LAST NAME, FIRST NAME)

EMPLOYEE ID

PARTICIPANT NAME (LAST NAME, FIRST NAME)

PARTICIPANT ID

I attest that these services were delivered and received consistent with the Individual Support Plan and that I am in compliance with all waiver requirements. I understand that Medicaid is the payer of last resort.

Employee Signature Date

Employer Signature Date

SERVICE DATE (Month, Day, Year)	MILEAGE (Round to nearest mile)	SERVICE
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Please fax WITHOUT COVERSHEET toll free to 1-866-571-3682 or mail to Acumen, 4542 East Inverness Ave.Suite 210, Mesa, AZ 85206.

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