

REIMBURSEMENT FOR CLINIC PARTICIPATION

Michigan Department of Health and Human Services

Children's Special Health Care Services Plan Division

1. You MUST check one

☐ Field Clinic

☐ CMS Clinic

☐ Otology Clinic


Instructions:

- Complete all information including **Item 1 above**.
- This form and signatures MUST BE ORIGINAL.
- Photocopies or stamped signatures will NOT be accepted.
- For inquiries or questions-contact the email address to the right

- Email this form along with ORIGINAL RECEIPTS to the following address:

MDHHS-MSAPay-Inbox@michigan.gov

Section 1 - Clinic and Participating Provider Information

2. Name of facility where services were provided.		3. Clinic Location (City)	4. Type of Clinic
5. DATE (S) Clinic was held		6. BEGIN Time First day	7. ENDING Time Last day
8. Participating Provider Name		9. Professional Specialties (if any) <input type="checkbox"/> Physician <input type="checkbox"/> Other (specify):	
<ul style="list-style-type: none">• I certify that the information on this form is true and complete to the best of my knowledge• An ORIGINAL signature is required.• Photocopied or stamped signatures will not be accepted. 		10. Provider Signature _____ Date Signed _____	
11. SEND PAYMENT TO: (Name of Facility, Clinic, P.C., or Provider)		<ul style="list-style-type: none">• If payment is to a Facility, Clinic, or P.C., use FEDERAL ID No.• If payment is to an individual, use SOCIAL SECURITY No. <p style="text-align: center;">↓ Do NOT Use Both ↓</p>	
12. Mailing Address			
City	MI	ZIP Code	
		13 a. Federal Employer ID Number	13 b. Social Security Number.

Travel Reimbursement Instructions

- Complete **Section 2** if travel reimbursement is being requested.
- A copy of the Clinic Registration Form must be attached.
- Reimbursement is based upon current State Standardized Travel Regulations.
- You **must** attach **original receipts** for all corresponding lodging, airline ticket, car rental, taxi, parking, and toll expenses.
- All requests for car rental reimbursement must include **justification** for the rental.

Section 2 - Travel Reimbursement Information

14. DEPARTURE Date, Time, and City		
15. RETURN Date and Time		
16. Round Trip Miles Traveled to Clinic and Back		
17. No. of Breakfasts	No. of Lunches	No. of Dinners
18. Number of Nights of LODGING (A Receipt is required)		
19. AIRFARE (A Receipt is required)		\$
20. CAR RENTAL (A Receipt is required)		\$
21. MISC. (Parking, tolls, cabs, etc.) (A Receipt is required)		\$
22. Comments: (Use additional sheets if needed)		

For MDHHS Office Use Only

Professional Services	\$
Total Miles	
X \$. =	\$
Total Meals	\$
Total Lodging	\$
Airfare	\$
Car Rental	\$
Miscellaneous	\$
TOTAL	\$
Comments:	

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, gender identification or expression, sexual orientation, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.

AUTHORITY: P.A. 368 of 1978

COMPLETION: Is Voluntary