

Provider Proof of Service Delivery Documentation

Service Provider _____

Please fill out the information below and sign. Your signatures verify that the service that you were authorized to provide/receive thorough Maryland RecoveryNet was delivered on the date indicated below by the service provider that you requested.

Name _____

This was the provider I selected: yes ___ no ___ Explain: _____

Date of Service: _____ Service Type: ___Housing ___Employment

Client signature _____

Service Provider signature _____

Name _____

This was the provider I selected: yes ___ no ___ Explain: _____

Date of Service: _____ Service Type: ___Housing ___Employment

Client signature _____

Service Provider signature _____

Name _____

This was the provider I selected: yes ___ no ___ Explain: _____

Date of Service: _____ Service Type: ___Housing ___Employment

Client signature _____

Service Provider signature _____

Name _____

This was the provider I selected: yes ___ no ___ Explain: _____

Date of Service: _____ Service Type: ___Housing ___Employment

Client signature _____

Service Provider signature _____

Provider Note: this form must be signed (must be legible) by the service recipient for each day you are requesting reimbursement. Remember information about recipients and the services they receive are confidential. Refer to the Provider Mmanual for details on confidentiality. This document must be kept on the service site and made available on request by the RAC or DHMH staff. The Provider proof of service delivery documentation will be requested at time of audit and forms must be kept by the provider for five years.