

## PARTICIPANT/SELF-DIRECTION PAYMENT REQUEST FORM (PRF)

The requested item and amount must be approved in your Mi Via Service and Support Plan (SSP), Supports Waiver Individual Service Plan (ISP), and Self-Directed Budget. DO NOT use your own money to pay vendors. Conduent-FMA CANNOT reimburse you. **Initial PRFs must be submitted for payment within ninety (90) days from the date of service to meet timely filing requirements. Initial PRFs submitted past ninety (90) days from the date of service do not meet Medicaid timely-filing requirements and will be denied.**

*ATTACH A VENDOR COST QUOTE OR VALID INVOICE WITH THIS PAYMENT REQUEST FORM.*

*Future dated invoices **will not** be accepted.*

Conduent, Inc. Phone: 1-800-283-4465  
 P.O. Box 27460 FAX: 1-866-302-6787  
 Albuquerque, NM 87125

<b>Is this a correction to a PRIOR PRF?</b> Yes          No
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Print Member/Participant Name	
Member/Participant Medicaid Card Number	
Approved Budget Period	
Waiver Service Procedure Code/Modifier	
Describe Item Being Purchased	
Full Payment Amount (including all taxes)	
Is the item being purchased an EMOD?	<input type="checkbox"/> Yes <input type="checkbox"/> No
For Environmental Modifications (EMOD) Only	<input type="checkbox"/> First Installment <input type="checkbox"/> Second Installment <input type="checkbox"/> Job Completed
Request Date	
Print Name of Person Authorized to Sign the PRF	
Signature of Person Authorized to Sign the PRF	_____ Date of Signature

**BY SIGNING THE PRF, I ATTEST THAT I AM THE PERSON AUTHORIZED TO SIGN THE PRF. IF I AM THE PARTICIPANT, I ATTEST THAT I DO NOT HAVE A PLENARY OR LIMITED GUARDIANSHIP OR CONSERVATORSHIP OVER FINANCIAL MATTERS. IF I AM THE PARTICIPANT'S EMPLOYER OF RECORD (EOR) AND/OR AUTHORIZED REPRESENTATIVE, I ATTEST THAT I DO NOT RECEIVE PAYMENT FOR PROVIDING SELF-DIRECTED SERVICES TO THE PARTICIPANT. I ATTEST THAT I HAVE NOT PROVIDED THIS DOCUMENT PRE-SIGNED TO A VENDOR.**

Payee Name (Vendor Name)	Vendor Federal Tax ID#
Address Line 1	
Address Line 2	
City	State
	Zip

**CHECKS WILL BE MAILED TO THE PERSON AUTHORIZED TO SIGN THE PRF**

## **INSTRUCTIONS FOR COMPLETING THE PAYMENT REQUEST FORM (PRF)**

The PRF is used by the Centennial Care Self-Directed Community Benefits Program (SDCB), the Supports Waiver, and the Mi Via Program. Instructions 1 through 6 below apply to all programs:

1. **Is this a correction to PRF?** - If you are submitting a corrected PRF to replace one already provided please ensure you check of "Yes" on the top of the PRF.
2. **Print Member / Participant Name** - The participants name must match what is in FOCO S.
3. **Member/Participant Medicaid Card Number** - Please double check the number and ensure number is correct.
4. **Approved Budget Period** - Please included the dates of the current approved Participant/Self-Direction Budget.
5. **Waiver Service Procedure Code / Modifier** - Please ensure the Code/Modifier is filled out and is the correct Code/ Modifier.
6. **Description Item Being Purchased** - Item description must match description of attached quote or valid invoice and MUST BE APPROVED on the ISP or SSP and Budget.
7. **Full Payment Amount** - Must include the price of the good or services and all applicable taxes.
8. **Is the item being purchased an EMOD** - Please ensure that you check of "Yes" or "No."
9. **For EMOD Only** - Please ensure that you check off the appropriate Installment and/or if the job has been completed.
10. **Request Date** - Must be within ninety (90) days from the date of service to meet timely filing requirements.
  - a. The "request date" may be the date that the request for payment is being made unless:
    - i. Purchase of a Prepaid Cell Phone Service – Request Date must include the month the service will be used.
11. **Print Name of Person Authorized to Sign the PRF** - Name must match the name on file in FOCO S. The PRF must be signed and dated by the person authorized to sign the document. A PRF may not be signed prior to the delivery of services and a blank, signed PRF must never be provided to a service provider. See below for who is authorized.
12. **Payee Name (Vendor Name) & Vendor Federal Tax ID#** - The Vendor Name on the PRF must match the name of the Vendor on the Vendor Cost Quote or Valid Invoice.
13. **Cost Quote or Valid Invoice** - Must be submitted with the payment request form. Future dated invoices WILL NOT be accepted.

## **WHO IS AUTHORIZED TO SIGN THE PRF?**

### **SDCB Program:**

- 1) If the SDCB member has an EOR, the EOR is the only person authorized to sign the PRF. The member may also be their own EOR.

### **Mi Via Program:**

- 1) If the Mi Via participant has an EOR. The EOR is the person authorized to sign the PRF. The participant may be their own EOR.
- 2) A Mi Via participant is not required to have an EOR if all of his/her providers are vendors. If the participant selects to have an authorized signer, instead of an EOR, then only the person identified on the Authorization to Sign PRFs if no EOR form is authorized to sign the PRF.

### **Supports Waiver Program:**

- 1) The Supports Waiver participant must have an EOR. The EOR is the person authorized to sign the PRF. The participant may also be their own EOR.