PerformCARE®
8040 Carlson Road
Harrisburg, PA 17112

PROVIDER EDUCATION REIMBURSEMENT REQUEST FORM

APPROVAL PROCESS

Please submit the following information by email to sheller@performcare.org, by fax to 717-671-6571 or by mail to: PerformCare, Quality Management (QM) Department, Education Reimbursement Request, 8040 Carlson Road, Harrisburg, PA 17112.

Payment will not be reimbursed without following completed information:

- ✓ This ***completed*** form
- ✓ A formal copy of the training's description
- ✓ A completed W-9 ***only if*** the requester is an individual (not an agency). The W-9 must be signed and dated.

PerformCare recommends submission of the request **two weeks** prior to the training start date.

REIMBURSEMENT AMOUNTS

$50 for attending a half-day of training (2-4 hours per day)
$100 for attending a full day of training (5-8 hours per day)
$500 for attending multiple days of training for recognized certification programs

PAYMENT

PerformCare will send an email to the requester indicating the status of the request once it is received. If approved, a copy of the CEU and a copy of the PerformCare request status email must be submitted to PerformCare **within four weeks** of the training completion date. Payment will be issued by AmeriHealth Caritas directly to the designated Provider Organization or to the attendee.

PLEASE NOTE:

- This is not a registration form. Participants must register through the organization offering the training.
- PerformCare will reimburse for attendance at trainings only identified in the Opportunities list.
- PerformCare will honor requests on a first come first serve basis and funds are limited to one training per person as funds are capped.
- PerformCare reserves the right to distribute funding equitably throughout our network providers.
- All training dollars are from administrative funds and do not affect dollars for treatment of Members.

Name of Attendee (Printed):	Job Title:	Business Phone Number:	Business Email Address:
Agency:	Reimburse: __Agency OR __Individual	Direct Supervisor's Name (Printed):	
Title of Training:	Date of Training:	Hours of Training:	Cost of Training:
2021Reimbursement Mailing/Street Address:		City and State:	Zip Code:

Employee's Signature: _____ ***Date:*** _____

Direct Supervisor's Signature: _____ ***Date:*** _____

DO NOT WRITE BELOW THIS LINE

Has this person applied before for funding previously? Yes ____ No ____
Has the training been? Approved ____ Denied ____
Has the direct supervisor signed the form? Yes ____ No ____
Date applicant was notified _____
Remarks/Comments: