

MILEAGE REIMBURSEMENT INSTRUCTIONS

Make sure your timesheet is filled out completely and correctly. All entries must be printed neatly inside the boxes, without touching any border (see examples below). AM/PM bubbles must be filled completely. If letters or numbers are not within the boxes, or are not readable, payment may be delayed. Each shift worked must include Service Date, Time In with AM/PM, Time Out with AM/PM, and Service Code.

Fill circles like this:	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	Not like this:	<input checked="" type="radio"/> <input type="radio"/> <input type="radio"/>												
Fill boxes like this:	<table border="1"><tr><td>A</td><td>B</td><td>C</td><td>1</td><td>2</td><td>3</td></tr></table>	A	B	C	1	2	3	Not like this:	<table border="1"><tr><td>A</td><td>B</td><td>C</td><td>1</td><td>2</td><td>3</td></tr></table>	A	B	C	1	2	3
A	B	C	1	2	3										
A	B	C	1	2	3										

1. Employee Name. Print Employee's Name.

2. Employee ID. First seven digits of employee ID number.

3. Member Name. Print Member's Name.

4. Member ID. Seven digit member ID number.

5. Service Date. The date services were provided, in MM/DD format.

6. Odometer Start. Your odometer reading at the start of your trip. Round to the nearest mile.

7. Odometer End. Your odometer reading at the end of your trip. Round to the nearest mile.

8. Mileage. Total mileage for your trip. Round to the nearest mile. (Odometer End – Odometer Start = Mileage)

9. Specific Location of Appointment.

10. Med Trans Ref #. Given by Medicaid Transportation. Call 1-800-292-7114

11. Name of Health Care Provider.

12. Medical Office Rep Signature. Each medical visit must be verified and signed by a representative from the medical office.

13. Employee Signature.

15. Member Signature.

17. Provider Signature. (Consumer Direct Care Network Representative)

CONSUMER DIRECT CARE NETWORK		Medical Escort Mileage		Service Code: CFC A0080	
Round mileage to the nearest mile.					
Medical Escort Records are due every week. They are due by the Monday following the end of the week by Midnight. You may fax, drop off, or email them. Mail is discouraged as it can not guarantee timely pay. Due to the timing of the payroll cycle, late forms will result in late pay. Medical Escort Records must be signed AFTER all work is completed. Advance forms will not be accepted.					
Escort time is above and beyond time authorized on the MPQH services profile. All miles must be requested through Medicaid Transportation by calling 1-800-292-7114. For approved trips, if miles are not reimbursed through the Medicaid Transportation program, they can be requested to be paid by Consumer Direct by submitting your mileage request below. All Medical Escort trips must be verified by the physician or an authorized representative of the medical office.					
1	2	3	4	5	6
Service Date (MM/DD/YY)		Odo Start (last 3)		Odo End (last 3)	
7		8		9	
Med Trans Ref#		Name of Health Care Provider		By signing I verify this office is a Medicaid Provider and the Member attended this appointment	
10		11		12	
Service Date (MM/DD/YY)		Odo Start (last 3)		Odo End (last 3)	
13		14		15	
Med Trans Ref#		Name of Health Care Provider		By signing I verify this office is a Medicaid Provider and the Member attended this appointment	
16		17		18	
Service Date (MM/DD/YY)		Odo Start (last 3)		Odo End (last 3)	
19		20		21	
Med Trans Ref#		Name of Health Care Provider		By signing I verify this office is a Medicaid Provider and the Member attended this appointment	
22		23		24	
Service Date (MM/DD/YY)		Odo Start (last 3)		Odo End (last 3)	
25		26		27	
Med Trans Ref#		Name of Health Care Provider		By signing I verify this office is a Medicaid Provider and the Member attended this appointment	
28		29		30	
I certify that the services indicated about were provided to the Member by the Employee as recorded.		Employee Signature		Date (MM/DD/YY)	
Services were provided by the nearest Medicaid Provider. The Member was NOT in a hospital, nursing home, or institution. False information or misrepresentation constitutes Medicaid fraud and may result in dismissal from the program and/or criminal prosecution.		Member/PR Signature		Date (MM/DD/YY)	
		Provider Representative Signature		Date (MM/DD/YY)	
		Drop Off: 3301 Great Northern Ave. Ste 203 Missoula, MT 59808		41424	
Rev. 11/21/16		Fax: 1-855-486-7249		Email: edmts@consumerdirectcare.org	

14. Employee Signature Date. In MM/DD/YY format. This must be **on or after** the last day worked

16. Member Signature Date. In MM/DD/YY format. This must be **on or after** the last day worked

18. Provider Signature Date. In MM/DD/YY format. This must be **on or after** the last day worked