CONSUMER DIRECT CARE NETWORK

Shopping, CI, Waiver, Private Pay

MILEAGE REIMBURSEMENT INSTRUCTIONS

Make sure your form is filled out completely and correctly. All entries must be printed neatly inside the boxes, without touching any border. Service Code bubbles must be filled completely. If letters or numbers are not within the boxes, or are not readable, payment may be delayed.

All travel must be captured per day, including start location(s) and stop location(s) for each segment traveled. Entries must be detailed enough to allow CDCN to recreate travel routes and to verify the accuracy of mileage claimed. If the space provided does not allow you to capture all of your travel, you may combine mileage as needed and note clearly within the specific service date entry field.

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. Sunday that Started this pay period. The date of the Sunday at the beginning of the pay period, in MM/DD/YY format.

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

7. Miles. Total mileage for your trips per day. Round to the nearest mile. (Total of all trip segments)

8. Service Code. The code for the service you performed.

9. Odometer Start. Last 3 digits of odometer at the start of your trips for the day. Round to the nearest mile.

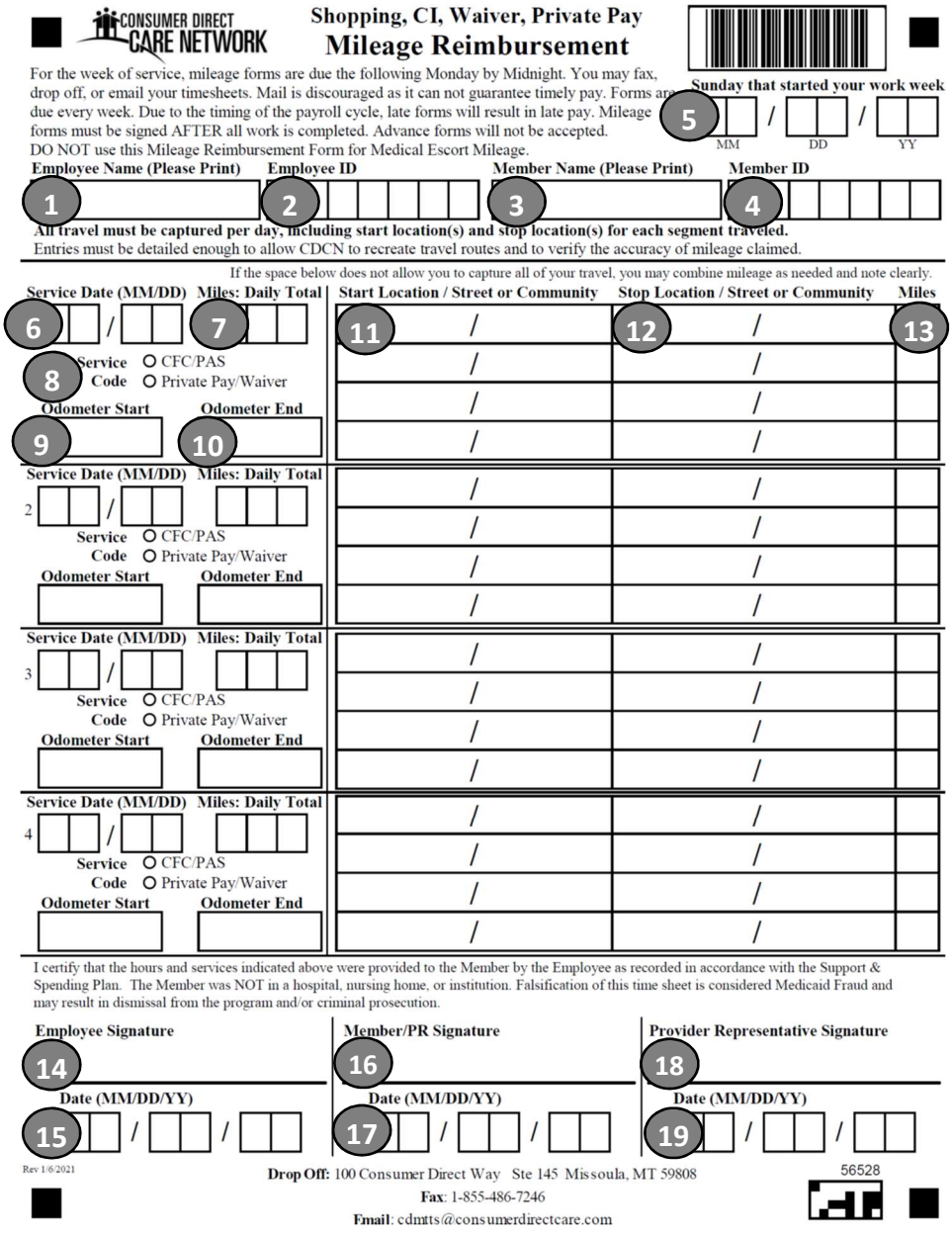
10. Odometer End. Last 3 digits of odometer at the end of your trips for the day. Round to the nearest mile.

11. Start Location / Street or Community. List the required start location details of your trip here. Ex. "*Client Home / 3rd Street*"

12. Stop Location / Street or Community. List the required start location details of your trip here. Ex. "*YMCA / Russel Ave*"

13. Miles. List miles for segment.

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



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

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