## 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.

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**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.

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**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.

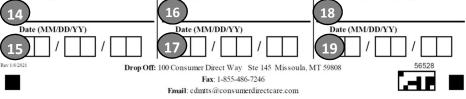
**11. Start Location / Street or Community.** List the required start location details of your trip here. Ex. "*Client Home / 3<sup>rd</sup> Street*"

**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

	ouraged as it can not guarantee timely pay. I oll cycle, late forms will result in late pay. Mi oleted. Advance forms will not be accepted. m for Medical Escort Mileage.	t yy fax, torms ar leage 5 MM / DD / YY
All travel must be captured per day, includ Entries must be detailed enough to allow CDC	N to recreate travel routes and to verify the	accuracy of mileage claimed.
Service Date (MM/DD) Miles: Daily Total		you may combine mileage as needed and note clearly. Stop Location / Street or Community Miles 12 / 13
Service O CFC/PAS Code O Private Pay/Waiver Odometer Start Odometer End		
9 Service Date (MM/DD) Miles: Daily Total	/	/
2 / / Date O CFC/PAS	/ /	/
Code O Private Pay/Waiver Odometer Start Odometer End	/	/
Service Date (MM/DD) Miles: Daily Total		
Service O CFC/PAS Code O Private Pay/Waiver Odometer Start Odometer End	/	
Service Date (MM/DD) Miles: Daily Total	/	
4 / / / / / / / / / / / / / / / / / / /	1	1
Odometer Start Odometer End	/	/
I certify that the hours and services indicated above were provided to the Member by the Employee as recorded in accordance with the Support & Spending Plan. The Member was NOT in a hospital, nursing home, or institution. Falsification of this time sheet is considered Medicaid Fraud and may result in dismissal from the program and/or criminal prosecution.		
Employee Signature	Member/PR Signature	Provider Representative Signature



**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