



# 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 / 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

**Shopping, CI, Waiver, Private Pay  
Mileage Reimbursement**

Sunday that started your work week

For the week of service, mileage forms are due the following Monday by Midnight. You may fax, drop off, or email your timesheets. Mail is discouraged as it can not guarantee timely pay. Forms are due every week. Due to the timing of the payroll cycle, late forms will result in late pay. Mileage forms must be signed AFTER all work is completed. Advance forms will not be accepted. DO NOT use this Mileage Reimbursement Form for Medical Escort Mileage.

Employee Name (Please Print) Employee ID Member Name (Please Print) Member ID

5 / /

MM DD YY

1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_

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 below does not allow you to capture all of your travel, you may combine mileage as needed and note clearly.

Service Date (MM/DD)	Miles: Daily Total	Start Location / Street or Community	Stop Location / Street or Community	Miles
6 / /	7	11 /	12 /	13
8	Service <input type="radio"/> CFC/PAS Code <input type="radio"/> Private Pay/Waiver	/	/	
9	Odometer Start Odometer End	/	/	
2 / /		/	/	
8	Service <input type="radio"/> CFC/PAS Code <input type="radio"/> Private Pay/Waiver	/	/	
9	Odometer Start Odometer End	/	/	
3 / /		/	/	
8	Service <input type="radio"/> CFC/PAS Code <input type="radio"/> Private Pay/Waiver	/	/	
9	Odometer Start Odometer End	/	/	
4 / /		/	/	
8	Service <input type="radio"/> CFC/PAS Code <input type="radio"/> Private Pay/Waiver	/	/	
9	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 \_\_\_\_\_ Date (MM/DD/YY) \_\_\_\_\_

Member/PR Signature \_\_\_\_\_ Date (MM/DD/YY) \_\_\_\_\_

Provider Representative Signature \_\_\_\_\_ Date (MM/DD/YY) \_\_\_\_\_

Rev 1/6/2021 Drop Off: 100 Consumer Direct Way Ste 145 Missoula, MT 59808 56528  
 Fax: 1-855-486-7246 Email: cdnmts@consumerdirectcare.com

**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