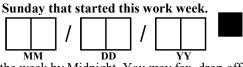


## Medical Escort Verification Service Code: CFCA0080

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 cannot 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 Caregivers must call Medicaid Transportation for approval of a medical appointment and then mileage that is not reimbursed by Medicaid Transportation can be submitted through the DirectMyCare Web portal. This form is intended to verify the Medical appointment and requires the address/location/name of provider and an office rep signature.

Employee Name (Please Print)Employee ID		Member Name (Please Pi	rint) N	Member ID		
Service Date (MM/DD)  Last 3 digits of odometer Odo Start  Specific Location of Appointment:    1  /						
office is a Medicaid Provider and the Member attended this appointment.			Medical Office Rep. Signature:			
Service Date (MM/DD) Codo Start Odo Stop Specific Location of Appointment:						
2 Med Trans Ref#: Name of Health C	are Provider:	By signing, I verify this	Medical C	Office Rep. Sign:	ature:	
		office is a Medicaid Provider and the Member attended this appointment.		1 0		
Service Date (MM/DD) Last 3 digits of odometer Odo Start Odo Stop Specific Location of Appointment:						
3 Med Trans Ref#: Name of Health Ca		By signing, I verify this	Madiaal	Office Rep. Sign:		
Med Trans Ref#:  Name of Health Care Provider:		office is a Medicaid Provider and the Member attended this appointment.		Jince Kep. Signa	1111C.	
Service Date (MM/DD) Last 3 digits of odometer Odo Start Odo Stop Specific Location of Appointment:						
4 / / Odo Start	Ddo Stop Specin					
Med Trans Ref#:    Name of Health Care Provider:    By signing      Office    office i      Provider and			Medical C	Office Rep. Signa	ature:	٦
attended this appointment.						
Service Date (MM/DD)  Last 3 digits of odometer Odo Start  Specific Location of Appointment:    5  /						
Med Trans Ref#:  Name of Health Care Provider:  By signing, I verify this office is a Medicaid  Med    Provider and the Member attended this appointment.  Provider and the Member attended this appointment.  Med			Medical C	Office Rep. Sign	ature:	
I certify that the services indicated about	Employee Signatu	е	Date	(MM/DD/YY)		_
were provided to the Member by the Employee as recorded. Services were				/		
provided by the nearest Medicaid Provider.	Member/PR Signa	ember/PR Signature		(MM/DD/YY)		_
The Member was NOT in a hospital, nursing home, or institution. False information or					]/[	٦
misrepresentation constitutes Medicaid fraud	Provider Representative Signature		Date	Date (MM/DD/YY)		
and may result in dismissal from the program and/or criminal prosecution.					]/	٦
		Way Sta 120 Missaula MT			04368	-

DropOff: 100 Consumer Direct Way Ste 120 Missoula, MT 59808Fax: 1-855-486-7246Email: cdmtts@consumerdirectcare.com