Medical Escort Verification

Service Code: CFCA0080
Round mileage to the nearest mile.

Sunday that started this work week.

MM	/	DD	/	YY
	/		/	

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 Print)	Member ID

#	Service Date (MM/DD)	Odo Start (*Last 3 digits of odometer*)	Odo Stop	Specific Location of Appointment:
1	/			

Med Trans Ref#:	Name of Health Care Provider:	By signing, I verify this office is a Medicaid Provider and the Member attended this appointment. Medical Office Rep. Signature:

#	Service Date (MM/DD)	Odo Start (*Last 3 digits of odometer*)	Odo Stop	Specific Location of Appointment:
2	/			

Med Trans Ref#:	Name of Health Care Provider:	By signing, I verify this office is a Medicaid Provider and the Member attended this appointment. Medical Office Rep. Signature:

#	Service Date (MM/DD)	Odo Start (*Last 3 digits of odometer*)	Odo Stop	Specific Location of Appointment:
3	/			

Med Trans Ref#:	Name of Health Care Provider:	By signing, I verify this office is a Medicaid Provider and the Member attended this appointment. Medical Office Rep. Signature:

#	Service Date (MM/DD)	Odo Start (*Last 3 digits of odometer*)	Odo Stop	Specific Location of Appointment:
4	/			

Med Trans Ref#:	Name of Health Care Provider:	By signing, I verify this office is a Medicaid Provider and the Member attended this appointment. Medical Office Rep. Signature:

#	Service Date (MM/DD)	Odo Start (*Last 3 digits of odometer*)	Odo Stop	Specific Location of Appointment:
5	/			

Med Trans Ref#:	Name of Health Care Provider:	By signing, I verify this office is a Medicaid Provider and the Member attended this appointment. Medical Office Rep. Signature:

I certify that the services indicated about were provided to the Member by the Employee as recorded. 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.

Signature	Date (MM/DD/YY)
Employee Signature	/ /
Member/PR Signature	/ /
Provider Representative Signature	/ /

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