



# Medical Escort Verification

Service Code: CFCA0080

Round mileage to the nearest mile.

Sunday that started this work week.

<input type="text"/>	/	<input type="text"/>	/	<input type="text"/>
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 at 1-800-292-7114 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.**

<b>Employee Name (Please Print)</b>	<b>Employee ID</b>	<b>Member Name (Please Print)</b>	<b>Member ID</b>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

<b>Service Date (MM/DD)</b>	<i>Last 3 digits of odometer</i> <b>Odo Start</b>	<b>Odo Stop</b>	<b>Specific Location of Appointment:</b>
1 <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>Med Trans Ref#:</b>	<b>Name of Health Care Provider:</b>	By signing, I verify this office is a Medicaid Provider and the Member attended this appointment.	<b>Medical Office Rep. Signature:</b>
<input type="text"/>	<input type="text"/>		<input type="text"/>

<b>Service Date (MM/DD)</b>	<i>Last 3 digits of odometer</i> <b>Odo Start</b>	<b>Odo Stop</b>	<b>Specific Location of Appointment:</b>
2 <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>Med Trans Ref#:</b>	<b>Name of Health Care Provider:</b>	By signing, I verify this office is a Medicaid Provider and the Member attended this appointment.	<b>Medical Office Rep. Signature:</b>
<input type="text"/>	<input type="text"/>		<input type="text"/>

<b>Service Date (MM/DD)</b>	<i>Last 3 digits of odometer</i> <b>Odo Start</b>	<b>Odo Stop</b>	<b>Specific Location of Appointment:</b>
3 <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>Med Trans Ref#:</b>	<b>Name of Health Care Provider:</b>	By signing, I verify this office is a Medicaid Provider and the Member attended this appointment.	<b>Medical Office Rep. Signature:</b>
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<b>Service Date (MM/DD)</b>	<i>Last 3 digits of odometer</i> <b>Odo Start</b>	<b>Odo Stop</b>	<b>Specific Location of Appointment:</b>
4 <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>Med Trans Ref#:</b>	<b>Name of Health Care Provider:</b>	By signing, I verify this office is a Medicaid Provider and the Member attended this appointment.	<b>Medical Office Rep. Signature:</b>
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<b>Service Date (MM/DD)</b>	<i>Last 3 digits of odometer</i> <b>Odo Start</b>	<b>Odo Stop</b>	<b>Specific Location of Appointment:</b>
5 <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>Med Trans Ref#:</b>	<b>Name of Health Care Provider:</b>	By signing, I verify this office is a Medicaid Provider and the Member attended this appointment.	<b>Medical Office Rep. Signature:</b>
<input type="text"/>	<input type="text"/>		<input type="text"/>

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.

<b>Employee Signature</b>	<b>Date (MM/DD/YY)</b>
<input type="text"/>	<input type="text"/>
<b>Member/PR Signature</b>	<b>Date (MM/DD/YY)</b>
<input type="text"/>	<input type="text"/>
<b>Provider Representative Signature</b>	<b>Date (MM/DD/YY)</b>
<input type="text"/>	<input type="text"/>

