

Fill circles like this: Not like this:

Fill boxes like this:

A	B				
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 Not like this:

A	B	C	1	2	3
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- Employee Name.** Print Employee's Name.
- Employee ID.** First seven digits of employee ID number.
- Member Name.** Print Member's Name.
- Member ID.** Seven-digit member ID number.
- Sunday that Started this pay period.** The date of the Sunday at the beginning of the pay period, in MM/DD/YY format. For example, if the first day of the week you worked was Tuesday, 11/15/16, then this would be **11/13/16**.
- Service Date.** The date services were provided, in MM/DD format.
- Shift/Drive Start.** The time your shift began, in HH:MM format. Choose **AM** or **PM** by filling in the correct circle.
- Shift/Drive End.** The time your shift ended, in HH:MM format. Choose **AM** or **PM** by filling in the correct circle.
- Service Code.** The code for the service you performed this shift. Start your code in the FIRST box. Leave any extra boxes empty.
- Hospitalization.** Answer "yes" if the member was in the hospital or any other institution during this week and explain.
- Comments.** Include the specific location for all shopping, CI, and Medical Escort time.
- Odo Start.** The mileage on your odometer at the start of your trip.
- Odo End.** The mileage on your odometer at the end of your trip.
- Employee Signature.**
- Member Signature.**
- Employer Signature Date.** In MM/DD/YY format. This must be **on or after** the last day worked.
- Member Signature Date.** In MM/DD/YY format. This must be **on or after** the last day worked.

Shopping & CI Verification TIMESHEET

For the week of service, timesheets 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. Timesheets are due every week. Due to the timing of the payroll cycle, late timesheets will result in late pay. Timesheets must be signed AFTER all work is completed. Advance timesheets will not be accepted.

Sunday that started this work week: **5** 1 2 / 2 9 / 2 4
MM DD YY

Employee Name (Please Print)		Employee ID		Member Name (Please Print)		Member ID	
1 John Doe		2 1 2 3 4 5 6		3 Jane Smith		4 7 6 5 4 3 2 1	
Service Date (MM/DD)	Shift/Drive Start	Shift/Drive End	Service Code				
6 1 0 1 / 0 1	7 1 0 : 1 5 <input checked="" type="radio"/> AM <input type="radio"/> PM	8 1 0 : 3 0 <input checked="" type="radio"/> AM <input type="radio"/> PM	9 C F C S H O P C I				
2 0 1 / 0 1	1 1 : 4 5 <input checked="" type="radio"/> AM <input type="radio"/> PM	1 2 : 0 0 <input type="radio"/> AM <input checked="" type="radio"/> PM	C F C M E D E S C				
3							
4							
5							

Was the Member in a hospital, emergency room, urgent care, nursing home, or any other institution or facility at any time during this week?
 Yes
 No
 Explain: 10

Comments: Include the specific destination for all Shopping or CI time.

11 Line 1:	Address	Odo Start	Odo End
	1234 Elm Street, SmallTown, MT 59888	12 12,34	13 12,352
Line 2:	Address	Odo Start	Odo End
	111 Maple Street, SmallTown, MT 59888	12,352	12,359
Line 3:	Address	Odo Start	Odo End
Line 4:	Address	Odo Start	Odo End
Line 5:	Address	Odo Start	Odo End

I certify that the hours, services, and tasks indicated above were provided to the Member by the Employer recorded. Medical Escort services were provided to 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.

Employee Signature	Date (MM/DD/YY)
14 John Doe	16 0 1 / 0 3 / 2 5
Member/PR Signature	Date (MM/DD/YY)
15 Jane Smith	17 0 1 / 0 3 / 2 5
Provider Representative Signature	Date (MM/DD/YY)
Sally Johnson	0 1 / 0 4 / 2 5

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

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