CONSUMER DIRECT CARE NETWORK

Medical Escort Mileage

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 can not 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 miles must be requested through Medicaid Transportation by calling 1-800-292-7114. For approved trips, if miles are not reimbursed through the Medicaid Transportation program, they can be requested to be paid by Consumer Direct by submitting your mileage request below. All Medical Escort trips must be verified by the physician or an authorized representative of the medical office.

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

1

Service Date (MM/DD/YY) / / **Odo Start (last 3):** **Odo End (last 3):** **Mileage:** **Specific Location of Appointment:**

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:**

2

Service Date (MM/DD/YY) / / **Odo Start (last 3):** **Odo End (last 3):** **Mileage:** **Specific Location of Appointment:**

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:**

3

Service Date (MM/DD/YY) / / **Odo Start (last 3):** **Odo End (last 3):** **Mileage:** **Specific Location of Appointment:**

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:**

4

Service Date (MM/DD/YY) / / **Odo Start (last 3):** **Odo End (last 3):** **Mileage:** **Specific Location of Appointment:**

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:**

5

Service Date (MM/DD/YY) / / **Odo Start (last 3):** **Odo End (last 3):** **Mileage:** **Specific Location of Appointment:**

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.

Employee Signature **Date (MM/DD/YY)** / /

Member/PR Signature **Date (MM/DD/YY)** / /

Provider Representative Signature **Date (MM/DD/YY)** / /

Drop Off: 100 Consumer Direct Way Ste 145 Missoula, MT 59808

Fax: 1-855-486-7246

Email: cdmtts@consumerdirectcare.com

41424

Instructions

These items must be completed for your record to be processed:

- **Employee Name**
- **Employee ID (first 7 digits)**
- **Member Name**
- **Member ID**
- **Employee Signature & Date**
  - Must be dated on or after the last day worked.
- **Member Signature & Date**
  - Must be dated on or after the last day worked.

Each line must include:

- Service Date (MM/DD/YY format)
- Odo Start (last 3 digits)
- Odo End (last 3 digits)
- Mileage – round to the nearest mile.
- Med Trans Ref #
- Specific Location
- Name of HCP
- HCP Signature

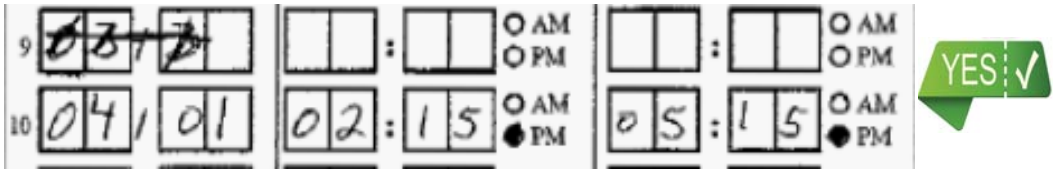
Make sure your record is filled out completely and correctly, with all entries made neatly inside the boxes. Payment may be delayed if letters or numbers are not printed neatly inside the boxes WITHOUT touching any lines, or are not readable.

Please continue on a second record if you run out of room on the first. Bold items on the list to the left must also be filled in on the second form.

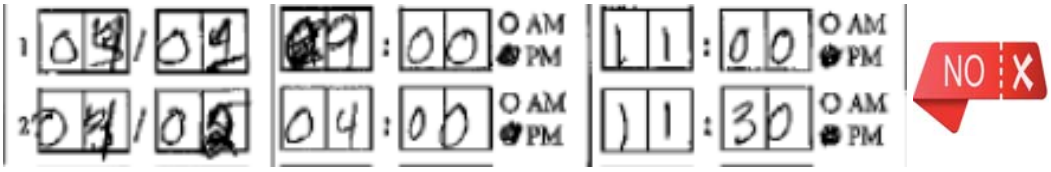
For best results use BLACK ink

Making Corrections

If you make a mistake **before** turning in your timesheet, cross out the incorrect line and rewrite the information on the next blank line like this:



Do not write over the top of incorrect information like this:



If you make a mistake and the timesheet gets returned to you for corrections, you **must** fill out a new timesheet.

Back page is for information only. Please do not submit it with your mileage form.