CARE NETWOR	KK	ing, CI, Waiver e Reimburs	-			
For the week of service, mileage for	orms are due the fol	llowing Monday by M	idnight. You may	Sunday that started	this work week.	
fax, drop off, or email your timesheets. Mail is discouraged as it can not guarantee timely pay. Forms are due every week. Due to the timing of the payroll cycle, late forms will result in late						
pay. Mileage forms must be signed AFTER all work is completed. Advance forms will not be accepted. <b>DO NOT</b> use this Mileage Reimbursement Form for Medical Escort Mileage.						
Employee Name (Please Print)     Employee ID     Member Name (Please Print)     Member ID						
				O CFC/PAS O Private Pay/Waiver		
Purpose of Trip & Specific Location:						
Service Date (MM/DD) O	dometer Start	Odometer End	Mileage	Service Code		
2 /				O CFC/PAS O Private Pay/Waiver		
Purpose of Trip & Specific Location:						
Service Date (MM/DD) O	dometer Start	Odometer End	Mileage	Service Code		
3 /				O CFC/PAS O Private Pay/Waiver		
Purpose of Trip & Specific Location:						
Service Date (MM/DD) O	dometer Start	Odometer End	Mileage	Service Code		
4				O CFC/PAS O Private Pay/Waiver		
Purpose of Trip & Specific Location:						
Service Date (MM/DD) O	dometer Start	Odometer End	Mileage	Service Code		
5 /				O CFC/PAS O Private Pay/Waiver		
Purpose of Trip & Specific Location:						
Service Date (MM/DD) O	dometer Start	Odometer End	Mileage	Service Code		
6				O CFC/PAS O Private Pay/Waiver		
Purpose of Trip & Specific Location:						
Service Date (MM/DD) O	dometer Start	Odometer End	Mileage	Service Code		
7				O CFC/PAS O Private Pay/Waiver		
Purpose of Trip & Specific Location:						
I certify that the hours and services indicated Employee Signature Date (MM/DD/YY)						
above were provided to the Member b Employee as recorded in accordance v	by the with the	8				
Support & Spending Plan. The Member was						
institution. Falsification of this time sh considered Medicaid Fraud and may re-		Member/PR Signature		Date (MM/DD/YY)		
dismissal from the program and/or crin prosecution.					/	
Drop Off: 100 Consumer Direct Way Ste 145 Missoula, MT 59808 14798						

Email: cdmtts@consumerdirectcare.com

## **Mileage Reimbursement Instructions**

These items must be completed for your time sheet to be processed:

- Employee Name
- Employee ID
- Sunday that Started this Pay Period

   Example: if the first day worked was Tues.
   the 12<sup>th</sup>, this would be Sun. the 10<sup>th</sup>.
- Member Name
- Member ID
- Employee Signature & Date • Date must be on or after the last day worked.
- Member Signature & Date • Date must be on or after the last day worked.

## Each line of time must include:

- Service Date (MM/DD format)
- Odometer Start (last 3 digits)
- Odometer End (last 3 digits)
- Total Mileage (round to nearest mile)
- Service Code
- Purpose of Trip

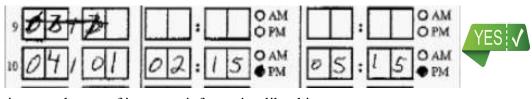
Make sure your mileage form is filled out completely and correctly, with all entries made neatly inside the boxes. Payment may be delayed if letters or numbers are not printed neatly inside the boxes WITHOUT touching any lines, or are not readable.

Please continue on a second mileage form 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.

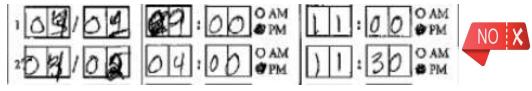
## For best results use BLACK ink

## **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.

Mileage Service Codes			
Service	Service Code		
CFC	CFCA0080		
PAS	CFCA0080		
Private Pay	MILEAGE		
Waiver	MILEAGE		

