

# Consumer Choices Option Mileage Form

Member name: \_\_\_\_\_ Medicaid number: \_\_\_\_\_

Member signature: \_\_\_\_\_

Employee name: \_\_\_\_\_ Social Security number: \_\_\_\_\_

Employee signature: \_\_\_\_\_

Rate per mile: \_\_\_\_\_

Date	Destination (city, town or area)	Purpose	Odometer Start	Odometer Stop	Miles this trip
<b>Total</b>					

By my signature above, I certify and attest that the services that are being submitted for payment have been delivered and received in accordance with the participant’s plan of care. I declare that I am eligible to receive payment through a Medicaid program, that neither I nor the company I am employed by appear on any federal or state exclusion lists, and that neither I nor the owners of the company I am employed by have a criminal history that would exclude us from payment. I understand that payment of this claim may be from the use of federal and state funds, and that I may be prosecuted under applicable federal or state laws, for any false claims, statements or documents or concealment of material fact. Misuse of funds may result in me being fined or penalized for, including but not limited to, the repayment of this claim, collection costs and legal fees. I understand that any costs incurred due to the submission of a false claim is my legal responsibility. If I am paid in error, I understand it is my responsibility to repay the funds not owed to me. I also authorize Veridian Fiscal Solutions to withdraw/withhold any overpaid funds from future payment. Medicaid fraud is considered a crime, will be investigated and is punishable by law.

