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
Total					

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.

Veridian Fiscal Solutions