

Mileage Log

Employee Name (driver): ______ Member driving for: _____

Pay Period Beginning (MM/DD/YY): _____ Pay Period Ending (MM/DD/YY): _____

ATTENTION: Mileage logs received after the payroll schedule due date will be paid with the following payroll. NO EXCEPTIONS. LKiChoice is not responsible for reimbursement that exceeds the authorization. Falsification of this mileage log is considered Medicaid fraud and may result in dismissal from the program and/or criminal prosecution.

REMINDER: To be eligible for mileage reimbursement, you must be the owner of the insured vehicle.

Date:				Medical OR	
Month/Day/Year	То	From	Purpose/Description	Non-Medical	Total Miles/Trip
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Page _____ of ____

Total miles/Trips for this page: _____

It is your responsibility to verify that your completed and accurate mileage log has been received by LKiChoice once submitted via mail, fax, or email. <u>Please allow 48 hrs. before verification contact.</u>

Member/POA/Guardian "I, the member or managing party, certify that the above employee drove the miles/trips listed for this member, the services were provided in accordance with the care plan, and the member was NOT in a hospital, nursing home, or institution.	Signature:	Date signed:///	
Employee "I, the employee of this member, certify that the miles/trips driven and listed for this member, were provided in accordance with the care plan, and the	Signature:	Date signed://	
member was NOT in a hospital, nursing home, or institution.	Phone Number:	_ Email:	
	Please check your Funding Source:		
	Independent Care- iCare Incl Inty:	usa	

Submit to LKiChoice at: 106 S Beaumont Rd, Prairie du Chien, WI 53821, Fax # 1-844-634-7225, OR Payroll

email: payroll@lkichoice.com

OFFICE USE ONLY

Website: www.lkichoice.com PH # 1-844-534-7225