Lori Knapp CHOICE™
Part of the AssuranceSD Family

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: Month/Day/Year	To	From	Purpose/Description	Medical OR Non-Medical	Total Miles/Trip

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. Please allow 48 hrs. before verification contact.

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 member was NOT in a hospital, nursing home, or institution.

Signature: _____ Date signed: ____/_____/____

Phone Number: _____ Email: _____

Please check your Funding Source:

❑MyChoice ❑CareWi (MCW) ❑ Independent Care- iCare ❑Inclusa ❑ Lakeland Care Inc
❑ Menominee ITOW ❑CLTS County: _____ ❑Other: _____

Submit to LKiChoice at: 106 S Beaumont Rd, Prairie du Chien, WI 53821, Fax # 1-844-634-7225, OR Payroll email: payroll@lkichoice.com
Website: www.lkichoice.com PH # 1-844-534-7225

OFFICE USE ONLY

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