Vendor Mileage Invoice

Is this a correction to a PRIOR Mileage Invoice? ☐ YES ☐ NO

PARTICIPANT INFORMATION		
Full Name	ID	Program/Plan
VENDOR INFORMATION		
Full Name	Driver's License #	License Plate #
Vehicle Year	Vehicle Model	Service Code:

PAYMENT INFORMATION			
Date	Destination (From/To)	Purpose of Trip	Odometer Miles
			Start _____ End _____ Miles _____
			Start _____ End _____ Miles _____
			Start _____ End _____ Miles _____
			Start _____ End _____ Miles _____
			Start _____ End _____ Miles _____
			Start _____ End _____ Miles _____
		SUBTOTAL (miles)	
		TOTAL MILES x $ _____ (per mile)	**$**

I certify that this invoice is true and correct.

_____ _____

Driver Signature Date

I certify that the travel requested is approved on the member/participant's Service & Support Plan/Budget, and proper driver's license, insurance and vehicle registration have been verified.

_____ _____

Employer Signature **Date**

Please note, according to Medicaid timely-filing requirements, requests for payment must be submitted within 90 days of service.

Please send this completed form to Conduent

Fax: 866.302.6787
Email: docprocessing@conduent.com

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Albuquerque, NM 87125-7460