



Big Sky Waiver & SDMI Services and Medical Mileage



Employee Name: \_\_\_\_\_

Last Four Digits of Social Security # \_\_\_\_\_ Express Job # \_\_\_\_\_

Member Name: \_\_\_\_\_

Pay Period End Date: \_\_\_\_\_

Non-Medical Mileage - (shopping, errands, etc.)

Date:	Where:	Odometer start:	Odometer end:	Total Miles:
Date:	Where:	Odometer start:	Odometer end:	Total Miles:
Date:	Where:	Odometer start:	Odometer end:	Total Miles:
Date:	Where:	Odometer start:	Odometer end:	Total Miles:
Date:	Where:	Odometer start:	Odometer end:	Total Miles:
Date:	Where:	Odometer start:	Odometer end:	Total Miles:
Date:	Where:	Odometer start:	Odometer end:	Total Miles:
Date:	Where:	Odometer start:	Odometer end:	Total Miles:
Date:	Where:	Odometer start:	Odometer end:	Total Miles:

**Medical Mileage Reimbursement** All medical mileage must be called into Medicaid Transportation and approved for mileage reimbursement.  
**Call Medicaid Transportation at 1-800-292-7114 or 406-443-6100.**

Employee Signature \_\_\_\_\_

Date - \_\_\_\_\_

*By signing here I certify that I worked the hours recorded and completed the work tasks assigned*

*Last Day of Service*

Member Signature \_\_\_\_\_

Date - \_\_\_\_\_

*By signing here I certify that the employee has worked the hours recorded and completed the tasks assigned.*

*Last Day of Service*

**Misrepresentation constitutes fraud.**

**OFFICE USE ONLY:**

Express Initials \_\_\_\_\_

Date: \_\_\_\_\_