Self-Direction VENDOR Mileage Invoice Form

Is this a correction to a PRIOR Mileage Invoice? ☐ Yes ☐ No

Member/Participant Name_____ Driver Name_____

Service Code: T2049 Driver's License # _____

Vehicle Year_____ Model_____ License Plate_____

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:_____
			Start: End: Miles:_____

I certify that this invoice is true and correct.

Subtotal (miles) _____

Total miles x $_____ (per mile) = $ _____

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.

Member/ Participant/Employer of Record (EOR) Signature _____ Date_____

Please FAX or mail this completed form to Xerox. Please note, according to Medicaid timely-filing requirements, requests for payment must be submitted within 90 days of service.

FAX number: 1-866-302-6787, Phone: 1-866-916-0310
Mailing address: Xerox, PO Box 27460, Albuquerque, NM 87125-7460