WORKERS' COMPENSATION MILEAGE REIMBURSEMENT REQUEST

Record your mileage from your point of departure to the medical provider's office or clinic. We suggest that you submit this form on a monthly basis. We also need the name and phone numbers to all medical providers. We must call and verify each visit unless you include with this form a printout from the provider's office (on office letterhead) that documents you attended the appointment(s). Without this information we can not issue any reimbursements. Please allow up to thirty (30) days for processing.

Employee: _____ Employer: _____

Claim number: _____ Date of accident: _____

DATE	The address you drove from (street, city, state, zip)	Name, address and phone number of TREATING DOCTOR/HOSPITAL/ FACILITY that you drove to	MILEAGE (round trip)

This is a true and accurate record of miles driven TOTAL MILES: _____

_____ Date request submitted: _____

(your signature)