Name:
Employer:

Claim #:
Date of Injury:

MILEAGE REIMBURSEMENT REQUEST

Under the provisions of Workers' Compensation Act, you are entitled to reimbursement for mileage to and from your doctor's office or place of medical treatment. If you wish to be reimbursed for this expense, indicate below:

1. Date of each treatment
2. Where you left from
3. The name and address of where you went for treatment
4. The round trip mileage (please check your speedometer on your next visit)

When your trips have been confirmed with the treating facility, you will be reimbursed at the per mile rate currently set by your state's regulatory authority for workers' compensation. If you require additional forms, please advise.
Return the completed form to the above address.

DATES (*Fecha*)	FROM (ADDRESS) (*De Dirección*)	TO (ADDRESS) (*Para Dirección*)	ROUND TRIP MILEAGE (*Millaje*)

Total Mileage (*Millaje Totál*): ____________________

DATE (*Fecha*)

SIGNATURE (*Firma*)

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