MILEAGE REIMBURSEMENT

Claim Number: _____

Employee: _____

Employer: _____

Date of Accident: _____

Adjuster: _____

****PLEASE COMPLETE EACH SECTION OF THIS FORM FOR EACH DAY MILEAGE REIMBURSEMENT THAT IS BEING CLAIMED. (ALL MILES ARE SUBJECT TO VERIFICATION BEFORE PROCESSING.)**

DATE(S)	ADDRESS CLAIMANT STARTED FROM	NAME AND ADDRESS OF PHYSICIAN OR MEDICAL FACILITY:	ADDRESS OF FINAL DESTINATION AFTER DR'S APPT	ROUND TRIP MILES

PLEASE DO NOT WRITE IN THIS SPACE

Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company or self-insured program files a statement of claim containing any false or misleading information is guilty of a felony of the third degree.

Mail to:

Claimants Signature: _____

Date: _____

REV. 7/2014 D14-866