MILEAGE REIMBURSEMENT REQUEST **CLAIM NUMBER:**

You are entitled to reasonable reimbursement related to travel incurred for medical treatment. Please complete the attached form and return it to us. *Please note that if you do not have a physical originating address (PO Box is not acceptable) and a destination name and address, this will delay the processing for your mileage.

EMPLOYERS NAME:________________________________

EMPLOYEE NAME:________________________________

MAILING ADDRESS:________________________________

CITY:________________ STATE:______________ ZIP:________

DATE	FROM **(ADDRESS NEEDED)**	TO **(ADDRESS NEEDED)**	PURPOSE OF TRIP	MILES

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material misrepresentation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

I HAVE REVIEWED, UNDERSTAND, AND ACKNOWLEDGE THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

EMPLOYEE SIGNATURE: