

Mileage Reimbursement Request

Claimant: _____ **SSN:** _____ **Claim Number:** _____

DOI: _____ **Address:** _____

Agency: _____ **Adjuster:** _____

Date	Physician/Provider and Address	RT Mileage	Date Submitted	Paid	
				Y	N

Total Miles: _____ x .43 **Total Reimbursement Owed:** _____

I certify that the above Mileage is true, correct, and necessary for treatment arising from my Workers Compensation Injury.

Claimants Signature: _____