

Revised 12/05

WORKERS' COMPENSATION REQUEST FOR MILEAGE REIMBURSEMENT

NAME: _____ DATE OF INJURY: _____

SOCIAL SECURITY NUMBER: _____

Please reimburse me for mileage expenses, as listed below.

Please reimburse me for parking expenses/tolls charges, receipts attached.

Appointment Date	Itemized Expenses Parking/Tolls	Treating Physician or Medical Facility	Roundtrip Mileage

I certify that the information given is accurate and relates directly to my workers' compensation claim.

Signature: _____ Date: _____