MILEAGE REIMBURSEMENT REQUEST

(Petición de Reembolso del Kilometraje)

NAME: _____ CLAIM #: _____
(Nombre) (Número de Reclamo)

DOI: _____ SSN: _____
(Fecha de la Lesión) (Número de Seguro Social)

DATE (Fecha)	STARTING ADDRESS (Dirección inicial)	NAME AND ADDRESS OF MEDICAL FACILITY EXCLUDING PHARMACIES (Nombre y Dirección de la facilidad médica) (Excepto farmacias)	ENDING ADDRESS (Dirección final)	ROUNDTRIP MILEAGE (Kilometraje de Ida y Vuelta)

Please mark this box if you need another form for future mileage requests. ☐
(Marque por favor esta caja si usted necesita otra forma para las peticiones futuras del kilometraje.)

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. I hereby certify or affirm that the above mileage was incurred by me as necessary traveling expenses related to those medical facility visits pursuant to my workers' compensation case.

Claimant's Signature _____ Today's Date _____

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Intelligent Risk Management