MILEAGE REIMBURSEMENT SUBMISSION FORM

RE: Injured Employee: _____

Date of Injury: _____

Claim Number: _____

DATE	NAME OF PROVIDER	ADDRESS FROM	ADDRESS TO	PURPOSE OF TRIP	TOTAL MILES ROUND TRIP

Total Miles:	

The above mileage was incurred for the cure or relief of the above referenced work injury.

Fraud Warning: 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 may be guilty of a crime. Such misrepresentation may result in a forfeiture of benefits pursuit to section 1208 of the workers compensation act.

Injured Employee Signature: _____ Date: _____