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)	NAME AND ADDRESS OF MEDICAL FACILITY EXCLUDING PHARMACIES (Nombre y Dirección de la facilidad médica) (Excepto farmacias)	ROUNDTRIP MILEAGE TO AND FROM RESIDENCE (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 _____

mcim