MILEAGE REIMBURSEMENT

**\*\*PLEASE COMPLETE EACH SECTION OF THIS FORM FOR EACH DAY MILEAGE REIMBURSEMENT THAT IS BEING CLAIMED. (ALL MILES ARE SUBJECT TO VERIFICATION BEFORE PROCESSING.)**

**Claim Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_**

**Employee:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employer:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Date of Accident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Adjuster: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- | --- |
| DATE(S) | ADDRESS CLAIMANT STARTED FROM | NAME AND ADDRESS OF PHYSICIAN OR MEDICAL FACILITY: | ADDRESS OF FINAL DESTINATION AFTER DR’S APPT | ROUND TRIP MILES |
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| PLEASE DO NOT WRITE IN THIS SPACE |
| MILEAGE IS REIMBURSED AT $.445 CENTS PER MILE FOR TRAVEL TO/FROM AUTHORIZED MEDICAL PROVIDERS |
| 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. |
| Mail to: Division of Risk ManagementClaimantsSignature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Bureau of State Employees' WC Claims P.O. Box 8020Tallahassee, Florida 32314-8020 |

REV. 7/2014 D14-866