**MILEAGE/TRAVEL EXPENSE REIMBURSEMENT FORM**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Claim Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Injury \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Please reimburse me for travel expenses (not to include pharmacy travel) at $0.625 (effective 7/1/2022) per mile as listed below. Any mileage from 4/1/2022 to 6/30/2022 = $0.585/mile; 7/1/2011 to 3/31/2022 = $.555/mile; 7/01/2008 to 6/30/2011 = $0.505.

[ ] Please reimburse me for parking expense at the physician’s office, receipts attached.

\*\*Please note that all dates will need to be verified before reimbursement can be processed\*\*

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| --- | --- | --- | --- | --- | --- | --- |
| **Date of Appointment or Expense** | **Itemized Expenses *(include item & cost)*** | **Name of Physician or Provider** | **Address From *(for mileage purposes)*** | **Address To** ***(for mileage purposes)*** | **Round Trip Mileage** | ***For Office Use Only*** |
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|  |  |  |  |  | **TOTAL** |  |

Managed Care Innovations, LLC I certify that the information given is accurate,

P.O. Box 1140 that all medications and/or mileage for which I am

Richmond VA 23218-1140 requesting reimbursement directly relate to my workers compensation claim.

 Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_