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| MILEAGE REIMBURSEMENT FORM | | | | | | | | | | | | |
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| **Name:** | |  | | | **Address:** | |  | | | | | |
| **Claim Number:** | |  | | |  | |  | | | | | |
| **Date of Injury:** | |  | | |  | |  | | | | | |
|  |  | | | |  | |  | | | | | |
| Appt. Date | Provider Name and Address | | | | | | | | | Roundtrip Mileage | | Parking/Tolls**\*\*** |
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| ***\*\*****Receipts required for all parking and toll reimbursements.* | | | | | | Totals: | | | |  | |  |
|  | (\_\_\_\_\_\_\_\_\_ miles X \_\_\_\_\_ per mile) + (\_\_\_\_\_\_\_\_\_ parking/tolls) = | | | | | | | | |  | |  |
|  |  | | | | | | | | |  | |  |
| *This is a true and accurate account of my expenses.* ***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 is guilty of a felony.*** | | | | | | | | | | | | |
|  |  | | | | | | |  | | |  | |
| Claimant’s Signature: | | |  | | | | | | Date: |  | | |
| Adjuster’s Signature: | | |  | | | | | | Date: |  | | |