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 Management  Claimants  Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Bureau of State Employees' WC Claims  P.O. Box 8020  Tallahassee, Florida 32314-8020 | | | | |

REV. 7/2014 D14-866