Mileage Reimbursement Request

Claim Number: ___________________________ Date of Accident: _____________

Employee Name: _________________________

Please list trips taken to an authorized medical provider below.
Example: Home to Physician and Physician to Home or Work to Physical Therapy and Physical Therapy to Home. Be sure to include the full address of origin and destination.

Date	To	From	Round-Trip Mileage
		Total Mileage	
		Total Mileage x $0.445	$

I hereby certify and 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.

An injured employee or any other party making a claim under Florida Statute 440. 105 (7) shall provide his or her personal signature attesting that he or she has reviewed, understands, and acknowledges the following statement:

> "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 commits insurance fraud, punishable as provided in s. 817.234."

Signature: ____________________________________ Date: _____________