MILEAGE REIMBURSEMENT

PLEASE MAKE COPIES

Name: _____ Date: _____

Address: _____ Carrier: _____

_____ Carrier Case No.: _____

WCB Case No.: _____ Date of Accident: _____

PLEASE NOTE: Reimbursement should be submitted every three months. Please provide any receipts from doctors and physical therapy with this form. Payments are made by the insurance carrier usually within 45 days.

Date of Visit	Name of Doctor	Address of Doctor	Round Trip Mileage