MEDICAL MILEAGE REIMBURSEMENT FORM

Employee: _____ Social Security #: XXX-XX-_____
Street Address: _____ Claim #: _____
City/State/Zip: _____ Accident Date: _____

PLEASE COMPLETE ONE SECTION FOR EACH APPOINTMENT

DATE	ADDRESS STARTED FROM (i.e. home, work)	NAME & ADDRESS OF PHYSICIAN OR FACILITY	ADDRESS OF FINAL DESTINATION (i.e. home, work)	ROUND TRIP MILES

PLEASE **DO NOT** WRITE IN THIS BOX

Mileage is reimbursed at $.445 cents per mile for travel to and from authorized medical providers.
All Mileage is subject to verification before processing.

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.

I wish to be *reimbursed for the above mileage at the prevailing rate of $.445 cents per mile. I hereby certify or affirm that the above mileage was incurred by me as necessary traveling expenses related to those medical facility visits that are authorized under my workers' compensation case.

Claimant's Signature: _____ Date: _____

Mail to: Escambia County School District
Attention: Workers' Compensation
75 North Pace Boulevard
Pensacola, Florida 32505

Fax: 850/469-6107

*Reimbursement will be directly deposited into the bank account on file with the Escambia County School District.