3 MILEAGE/TRAVEL EXPENSE REIMBURSEMENT FORM

Name _____Claim Number_____

Address _____

City _____ State_____ Zip Code _____

Date of Injury _____

☐ Please reimburse me for travel expenses (not to include pharmacy travel) at $0.70 per mile (effective 1/1/2025) as listed below. Any mileage from 1/1/24 to 12/31/24 = $0.67; 1/1/23 to 12/31/23 = $0.655; 7/1/2022 to 12/31/2022 = $0.625/mile; 4/1/2022 to 6/30/2022 = $0.585/mile; 7/1/2011 to 3/31/2022 = $.555/mile; 7/01/2008 to 6/30/2011 = $0.505.

☐ Please reimburse me for parking expense at the physician's office, receipts attached.

Please note that all dates will need to be verified before reimbursement can be processed

Date of Appointment or Expense	**Itemized Expenses** ***(include item & cost)***	**Name of Physician or Provider**	**Address From** ***(for mileage purposes)***	**Address To** ***(for mileage purposes)***	**Round Trip Mileage**	***For Office Use Only***
					TOTAL	

Managed Care Innovations, LLC
PO Box 1140
Richmond VA 23218-1140

I certify that the information given is accurate, that all medications and/or mileage for which I am requesting reimbursement directly relates to my workers' compensation claim.

Signature: _____ Date: _____