

MEDICAL MILEAGE & PARKING REIMBURSEMENT REQUEST FORM

Employee Name: _____

Date of Accident: _____

Employer: _____

Claim Number/SSN: _____

Date of Service	Name & Address of Medical Provider	Round Trip Mileage	Parking Fees (attach Receipts)
TOTAL			

Please understand that you have only one year after the date of service by a medical provider to submit your request for mileage and parking reimbursement, otherwise it will not be paid by the insurance company, in accordance with the Official Code of Georgia Annotated § 34-9-203(c)(4).

Total Miles: _____ x \$.40 per mile = \$ _____ + Parking \$ _____ = Total: \$ _____

DATE

SIGNATURE