TRISTAR RISK MANAGEMENT

MILEAGE REIMBURSEMENT REQUEST FORM

WORKERS' COMPENSATION

P.O. Box 2805
Clinton, IA 52733-2805

Claimant:		Address:		
SS#:				
Claim #:		Phone:		
Date of Injury:		EMPLOYER:		
Date	**From Location**	**To Location**	**Purpose**	**Round Trip Mileage**

TOTAL MILES _____

X $.53/ MILE

SIGNATURE _____ AMOUNT DUE _____

Rule 18-6(E) Mileage Expenses

The payer shall reimburse an injured worker for reasonable and necessary mileage expenses for travel to and from medical appointments and reasonable mileage to obtain prescribed medications.The reimbursement rate shall be $0.53 cents per mile. The injured worker shall submit a statement to the payer showing the date(s) of travel and number of miles *traveled, with receipts for any other reasonable and necessary travel expenses incurred.*

Mileage reimbursement is reimbursed at the rate that was in effect on the date the mileage was incurred.

Effective Date	Mileage Rate (per mile)
Effective 01/01/12	47 cents
Effective 01/01/13	52 cents
Effective 01/01/14	53 cents
Effective 01/01/15	53 cents