Mileage Reimbursement

Employee: _____ Claim Number: _____ Date of Injury: _____

Employee Address: _____ Social Security Number: _____ Agency: _____

Please complete each section of this form for each day mileage reimbursement is being claimed. Allow 4 weeks for processing. SEICTF can not process fax documents; therefore, please mail this request to the address shown below.

Name and address of Physician or Medical Facility	**Date(s) of Service** (Six months or less)	**Beginning Address**	**Address of Final Destination after Appointment**	**Round Trip Miles** (Must be 50 miles or more)

I wish to be reimbursed for the above mileage. I understand the intentional reporting of false information will disqualify me from receiving further SEICTF benefits and could expose me to penalties or criminal charges. I certify the information to be correct to the best of my knowledge.

Mail to: SEICTF
PO Box 1390
Montgomery, AL 36102-1390

Claimant Signature: _____

Date: _____

Rev 5/17/2012

Accounting Code: Medical 7802 1100-03 780 010 6409