

Mileage Reimbursement

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

Employee Address: _____ Agency: _____

Please complete each section of this form for each day mileage reimbursement is being claimed. Allow 4 weeks for processing. Forms can be faxed, emailed or mailed back for processing to SEICTF at (334)223-6170, SEICTF.Email@finance.alabama.gov, or to PO Box 1390, Montgomery, AL 36102-1390. If you are an active state employee, payments will be processed through direct deposit.

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.

Claimant Signature: _____

Date: _____