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: _____

Revised 11/2/2026

FUND	DEPT	UNIT	OBJ	ACTV	FUNC
0780	010	6480	1151	7802	0592