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