

# MEDICAL TRAVEL EXPENSE FORM

Claim Number:		<p>You are entitled to reimbursement of medical travel expenses incurred because of your industrial injury. Complete the appropriate boxes below. Copies of supporting documents should be attached, for example: parking, cab, toll receipts. The law does not permit reimbursement for mileage to/from a pharmacy or visiting your attorney.</p> <p>This form may be photocopied as necessary. You should keep a copy for your records. For additional information visit our website at: <a href="http://www.bsgfdlaw.com">www.bsgfdlaw.com</a></p>
Date of Injury:		
Claimant's Name:		
Claimant's address:		
City, State & Zip:		
Employer's Name:		
Today's Date:		
SIGNATURE:		

DATE	TRAVELED FROM <small>(Include Address, i.e home, work)</small>	TRAVELED TO <small>(Include name &amp; address of medical provider)</small>	ROUND TRIP MILEAGE	PARKING <small>(include receipt)</small>	BRIDGE TOLLS <small>(include receipt)</small>	PUBLIC TRANS./ OTHER <small>(Include Receipts)</small>
<b>EXAMPLE</b> 1/5/99	<b>HOME-5151 Maple St</b> <b>Anytown, MD</b>	<b>Dr. J. Smith</b> <b>318 Main Street, Anytown,</b> <b>MD</b>	<b>8 miles</b>	<b>\$1.50</b>	<b>\$2.50</b>	<b>\$5.00</b>
<b>TOTAL</b>				<b>\$</b>	<b>\$</b>	<b>\$</b>