MILEAGE REIMBURSEMENT REQUEST

NAME:_____ HOME ADDRESS:_____

CLAIM NUMBER:_____ INSURED:_____

Date of Treatment	Starting Address (from home or work, enter H or W)	Name of Medical Facility with Address and Phone #	Round Trip Mileage	Reason for Trip (type of Txmt, PT, Rx, MRI. etc.)

For your protection Florida law requires the following to appear on this form:
Any person who knowingly and with intent, defraud, or deceive any Insurance Company files a claim or, an application containing any false, incomplete, or misleading is guilty of a third degree felony.