Medical Travel Log/Expense Reimbursement Voucher

For reimbursement of medical travel expenses only

Date of Travel:	Patient's Name:	Location of Physician or Treatment Facility:	Type of Treatment/ Diagnosis:	Number of Miles:	Total Reimbursement Amount:

I certify that the medical travel expense(s) listed above was incurred for transportation primarily for and essential to medical care for myself, or an eligible dependent. The medical care was provided by a physician in a licensed hospital or medical facility, and no element of personal pleasure, recreation or vacation was involved in the travel. Travel to and from a pharmacy does not qualify as medical care and is not eligible for reimbursement.

I authorize the above expense(s) to be reimbursed from my medical expense account. To the best of my knowledge, my statements on this form are true and complete. I certify all of the following: Either I, my Spouse, or my Dependent has received services on the dates indicated and the services qualify as valid medical care under Code Section 213(d). If I am a participant of a Health Savings Account and am also covered under a Limited Purpose medical expense account, the above qualifies as being eligible under the account. These expenses have not previously been reimbursed under the medical expense account or any other health plan and I will not seek reimbursement for them under my medical insurance or any other health plan. I understand that expenses reimbursed may not be used to claim any federal income tax deductions or credit. I also understand that I may be asked to provide further details about some expenses or a more detailed certification from me.

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Name of Participant (Please Print)

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Name of Employer

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Social Security Number

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Signature of Participant

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Date