Mileage and travel reimbursement

Name:
Period beginning ________________________________ Period ending ___________________________

Complete **one** line for each medical visit. The first line is an example. Return this form to your SFM claims representative if you would like your mileage expenses to be considered for reimbursement. The fax number is on your cover letter.

Date	From	To	Physician, hospital or purpose of visit	Miles (round-trip)
11/20	ABC Company	NowCare Clinic	Doctor Appointment	10
Total Mileage:				

Parking $ ______________________________

To be reimbursed for parking fees, a receipt must be attached.

Your Signature____________________________________ **Date**______________________________

Mileage will be reimbursed at the current rate allowed by state law. Reimbursement may be denied or delayed if information has not been documented correctly or cannot be verified. SFM reserves the right to verify mileage. Deliberately misrepresenting information in order to receive benefits to which you are not entitled is criminal fraud punishable under Minnesota law. SFM has zero tolerance for fraud.