MILEAGE REIMBURSEMENT FORM

FOR WORKERS' COMPENSATION

PUBLIC EMPLOYEE CLAIMS DIVISION
ARKANSAS INSURANCE DEPARTMENT
1200 West Third Street, Suite 201
Little Rock, Arkansas 72201
(501) 371-2700 Facsimile: (501) 371-2733

DATE	MEDICAL PROVIDER	ADDRESS	# OF MILES ROUNDTRIP

TOTAL MILES

X .39 PER MILE

TOTAL

NAME _____

ADDRESS _____

CITY, STATE, ZIP _____

CLAIM NUMBER _____

CLAIM MANAGER VERIFICATION FOR PAYMENT (FOR PECD USE)