

## INDIVIDUAL PROVIDER MILEAGE REIMBURSEMENT FORM

MONTH: <input type="text"/> <input type="text"/> <input type="text"/>	YEAR: 20 <input type="text"/> <input type="text"/>	IP Name:		
DAY	Number of Miles	IP Address:		
1				
2				
3		<b>* Check will be mailed to IP address listed above *</b>		
4		<b>I have attached copies of the required documents:</b>		
5		<input type="checkbox"/>	Current Driver's License	
6		<input type="checkbox"/>	Current Auto Insurance Information	
7				
8		<b>The authorization number for these services is:</b>		
9		AUL	<input type="text"/>	<input type="text"/>
10			<input type="text"/>	<input type="text"/>
11			<input type="text"/>	<input type="text"/>
12		<b>IP Signature (required) – sign below</b>		
13				
14				
15		Date:	<input type="text"/> <input type="text"/> <input type="text"/>	20 <input type="text"/> <input type="text"/>
16			Month	Day
17		<b>Participant Signature (required) – sign below</b>		
18				
19				
20		Date:	<input type="text"/> <input type="text"/> <input type="text"/>	20 <input type="text"/> <input type="text"/>
21			Month	Day
22		Please read the "Individual Provider Mileage Reimbursement Form Instructions" for more information on how to complete this form.		
23				
24				
25				
26		<b>Also note:</b> A W-9 for must be completed the first time you use this form. If you need a W-9 form or if you need to update your name or other information on the W-9 form after you submit it, please contact PPL Customer Service at our toll-free number:		
27				
28				
29				
30				
31				
<b>TOTAL MILES</b>				

**FAX OR MAIL THIS FORM TO PPL AT:** Fax: 1-866-484-2142  
Mail: ATTN: WA New Freedom, Public Partnerships, LLC, 20415 72<sup>nd</sup> Ave. S. #450, Kent, WA 98032