## MEDICAL TRAVEL EXPENSE FORM

Claim Number:				You are entitled to reimbursement of medical travel			
Date of Injury:				<ul> <li>expenses incurred because of your industrial injury. Complete the appropriate boxes below. Copies of supporting documents should be attached, for example: parking, cab, toll receipts. The law does not permit reimbursement for mileage to/from a pharmacy or visiting your attorney.</li> <li>This form may be photocopied as necessary. You should keep a copy for your records. For additional information visit our website at: <u>www.bsgfdlawcom</u></li> </ul>			
Claimant's Name:							
Claimant's address:							
City, State & Zip:							
Employer's Name:							
Today's Date:							
SIGNATU	RE:			_			
DATE	TRAVELED FROM (Include Address, i.e home, work)		TRAVELED TO (Include name & address of medical provider)	ROUND TRIP MILEAGE	PARKING (include receipt)	BRIDGE TOLLS (include receipt)	PUBLIC TRANS./ OTHER (Include Receipts)
EXAMPLE 1/5/99	HOME-5151 Maple St Anytown, MD		Dr. J. Smith 318 Main Street, Anytown, MD	8 miles	\$1.50	\$2.50	\$5.00
TOTAL					\$	\$	\$