

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

NAME _____

ADDRESS _____

CITY, STATE, ZIP _____

CLAIM NUMBER _____

X .31 PER MILE

TOTAL

CLAIM MANAGER VERIFICATION FOR PAYMENT (FOR PEC D USE)

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