Mileage & Parking Reimbursement Request

WC Mileage & Parking Reimbursement Request

WC Claim #	Name-First	M.I.	Last
Home Address	City	State	Zip Code
Injury Date	SS#	Department	

Date of Visit	From	To	Destination and Purpose	Total Miles	*Parking Expense

Total # of miles	
Total parking expenses	

A copy of your parking receipt must be attached for reimbursement. Fax this entire form along with the appropriate documentation to 404-657-1188. If you prefer, mail completed form and documentation to: DOAS-Risk Management Services, P.O. Box 38198, Atlanta, GA 30334-5525.

I My signature on this form indicates a true representation of mileage and medical trips, and that I have not previously been reimbursed for any of the above expenses, as of this day. . I understand any misrepresentation on mileage will be considered Fraud under the Ga Workers' Compensation Statute and subject me to possible fines and imprisonment under Georgia Statute.

_____ SIGNATURE

_____ DATE