MedBen
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MedBen Group # _____

HEALTH CARE SPENDING – MILEAGE RECORD
MILEAGE REIMBURSEMENT REQUEST FORM

Employee Name: _____ SS # _____

Street Address: _____

City, State, Zip: _____

Instructions: This form is to be completed if you are claiming, under your Health Care Spending (Health FSA), the mileage used to obtain qualified medical services from a physician, hospital or facility to prevent or alleviate a physical disease, defect or illness. Mileage will be reimbursed at a rate consistent with current Federal Guidelines. Be sure to provide all information requested by this form. If the form is incomplete, it will be returned to you. Print or type the information requested. Then date and sign the form.

Send this form to **MedBen, Specialty Services Unit, P.O. Box 1096, Newark, OH 43058-1096.**

Travel Date: _____ / _____ / _____

Name and address of facility traveled to:

_____

_____

Reason for Travel: _____
Describe medical treatment / service(s)

Patient Name: _____

Beginning Mileage: _____ Ending Mileage: _____

Total number of miles traveled to and from the above listed destination: _____

The current mileage reimbursement rate: 0.24 cents (2013)

To the best of my knowledge and belief, my statement in this Mileage Record Reimbursement Request Form is complete and true. I certify that I have incurred the miles described above on the dates indicated. I certify that the mileage was only used to obtain qualified medical services from a physician, hospital or facility to prevent or alleviate a physical disease, defect or illness. I have not been reimbursed previously under the Employers Benefit Plan or any other Benefit Plan, nor do I expect any of these expenses to be reimbursable elsewhere. I understand that these expenses may not be used to claim any Federal income tax deduction or credit. **WARNING: Any person, who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud or health care fraud under state and/or federal law. To report suspected fraud, call 1-877-9FRAUD 9 (1-877-937-2839).**

_____ _____
Employee Signature Date