Workers Compensation
Mileage Reimbursement

Name: _____

Address: _____

_____ Zip Code _____

Social Security #: _____
(Required)

Submit your mileage for all trips that exceed 5 miles round trip, if the purpose of the trip was to obtain medical care or purchase medically related items, such as prescriptions. Please submit this mileage request on a monthly basis until your file is closed.

Date	Miles	Destination

Mail to: State Self Insurance Fund
900 SW Jackson, Room 951-S
Landon State Office Building
Topeka KS 66612-1251