VA SAN DIEGO HEALTHCARE SYSTEM
INSTRUCTIONS FOR COMPLETING MILEAGE REIMBURSEMENT REQUEST FORM

Please note: All previous forms used for requesting mileage reimbursement are now obsolete and can no longer be accepted.

Section A

Box 1a: Veteran's name

Box 1b: Last four of the Veteran's Social Security Number only

Box 1c: Veteran's date of birth

Box 2a: Please mark as appropriate

Box 3a: Veteran's last name, first name, and middle initial

Box 3b: Last four digits of the Veteran's social security number

Box 3c: Veteran's date of birth

Section B

Box 1a: Please list the Veteran's actual residential address. Please do not list a P.O. Box.

Box 1b: Date the Veteran left home to come to VA appointment.

Box 1c: Method of transportation used. Examples: car, bus, train, etc.

Box 2a: Please mark as appropriate

Box 2b: Date the Veteran returned home following the VA appointment

Box 2c: Please mark as appropriate

Box 3: Veterans may claim for expenses other than mileage such as lodging and meals only if reimbursement for lodging and meals was pre-approved by the VA prior to commencing travel. In such cases, Veterans must include receipts.

(CONTINUED ON OTHER SIDE)

Box 4: Treating facility. Examples: VA Medical Center La Jolla, VA Clinic Mission Valley, VA Clinic Chula Vista, VA Clinic Oceanside, VA Clinic Sorrento Valley, VA Clinic Escondido, and VA Clinic El Centro.

Box 5: List address only if care facility was through Non-VA Care or the Choice Program such as a doctor's office in the local community in which the VA paid for the care. **If you are requesting reimbursement for VA approved care that was provided in a Non-VA care facility, please attach documentation from the doctor's office showing: 1) date(s) of completed appointments and, 2) the address where you received the care as this is necessary so we can calculate the miles travelled for reimbursement purposes.**

Section C

Please sign and date. Unsigned and/or undated forms cannot be accepted.

Submitting Completed Form

Please ensure all blocks have been completed including your signature and date. You may submit your completed form one of four ways:

1. Drop the completed form in the wall mounted box in the travel lobby on the first floor of the VA Medical Center in La Jolla.

2. Mail your completed form to the VA using the following address:

   San Diego VA Medical Center
   ATTN: Beneficiary Travel Office (136C)
   3350 La Jolla Village Drive
   San Diego, CA 92161

3. If you are at one our Community Based Outpatient Clinics located in Escondido, Oceanside, Sorrento Valley, Mission Valley, Chula Vista, or El Centro, you may give your completed form to clinic staff and they will forward it to the travel office at the VA Medical Center in La Jolla.

4. Fax your completed and signed form to the VA Beneficiary Travel office at 858-642-6418.

Upon receiving the completed form, travel office staff will process your claim. Funds will be electronically deposited into your bank account within 10-12 business days. Please note that per 38 CFR, Part 70, VA Beneficiary Travel regulations, all claims for mileage reimbursement must be submitted within thirty calendar days from the date care was received**. If you have any questions, please contact the Beneficiary Travel office directly at 858-552-8585, extension 5491 or 3826** Monday through Friday between the hours of 8:00a.m. and 4:30p.m. Thank you.

OMB Number: 2900-0798
Estimated Burden: 15 minutes

Department of Veterans Affairs

VETERAN/BENEFICIARY CLAIM FOR REIMBURSEMENT OF TRAVEL EXPENSES

Section A. Traveler's Information

1.a Name of Person Claiming Travel Reimbursement *(Last, First, Middle)*	1.b Claimant's SSN
	1.c Claimant's Date of Birth *(mm/dd/yyyy)*

2.a Claimant's status: *(check one)* **Complete 3.a, 3.b, 3.c and 3.d if Caregiver, Attendant or Donor is checked.**

☐ Veteran ☐ Caregiver (National Caregiver Program) ☐ Attendant (Medically authorized by VA) ☐ Donor (VA Transplant Care) ☐ Other

3.a Name of Veteran *(Last, First, Middle)*	3.b Veteran's SSN
	3.c Veteran's Date of Birth *(mm/dd/yyyy)*

Section B. Trip Information

1.a I am claiming travel reimbursement from address: *(Street, City, State, Zip)*	1.b Date Trip Began *(mm/dd/yyyy)*	1.c Travel by: *(e.g., car, train, bus, taxi)*
2.a I am claiming return travel reimbursement to the address in B.1.a above ☐ YES ☐ NO *(if no, provide the Street, City, State, Zip below)*	2.b Date Trip Ended *(mm/dd/yyyy)*	2.c Travel by: *(e.g., car, train, bus, taxi)*

3. I am claiming reimbursement of expenses other than mileage, such as tolls, parking, lodging, meals. ☐ YES ☐ NO

(If yes, itemize expenses below and provide a receipt for each expense claimed. Use reverse if additional space is required)

a.

b.

c.

d.

e.

f.

g.

h.

4. Treating Facility Name (VA or Non-VA location)	5. Treating Facility Address (Optional)

Section C. Statements and Certifications

Penalty Statement: There are severe criminal and civil penalties including fine or imprisonment, or both, for knowingly submitting a false, fictitious, or fraudulent claim

Certification: I have incurred a cost in relation to the travel claimed. I have not obtained transportation at Government expense, through the use of Government owned conveyance, or Government purchased tickets/tokens, or received other transportation resources at no-cost to me. I am the only person claiming for the travel listed. I have not previously received payment for the transportation claimed. I certify that the above information is correct.

Signature of Claimant	Date (mm/dd/yyyy)

INSTRUCTIONS FOR COMPLETING VETERAN/BENEFICIARY CLAIM FOR REIMBURSEMENT OF TRAVEL EXPENSES

Who is Eligible for Reimbursement of Travel Expenses

1. Veterans rated by VA 30% or more service-connected for travel relating to any condition
2. Veterans rated by VA less than 30% for travel relating to their service-connected condition
3. Veterans receiving VA pension benefits for travel relating to any condition
4. Veterans with annual income below the maximum applicable annual rate of pension for any condition
5. Veterans who are unable to defray the cost of travel (as defined in current Beneficiary Travel regulations)
6. Veterans traveling in relation to a Compensation and Pension (C&P) examination
7. Certain Veterans in certain emergency situations
8. Beneficiaries of other Federal Agencies when authorized by that agency
9. Allied beneficiaries when authorized by appropriate foreign government agency
10. Certain non-Veterans when related to care of a Veteran (Caregivers under the National Caregivers Program, medically required attendants, VA transplant care donor and support person, or other claimants subject to current regulatory guidelines)

Instructions

1. The claimant or legal representative of claimant may complete this form.
2. Allied beneficiaries and beneficiaries of other federal agencies are not required to complete Section A, Question 3a-c.
3. The form may be presented in person or mailed to VA health care facility where care was provided. Addresses of VA health care facilities can be found at: http://www.va.gov/directory *Note: The claim for travel benefits may also be done in person at a VA health care facility.*
4. Application for travel reimbursement must be done within 30 days of travel. *Exception: application beyond 30 days may occur when claim is a result of change in Beneficiary Travel eligibility.*
5. Receipts are required for allowable non-mileage expenses, e.g., bridge, road and tunnel tolls; parking; ferry fares; meals; lodging; and transport by bus, train, taxi or other public transportation. Prior approval is required for meals and lodging.
6. Application will be evaluated to determine eligibility for travel benefits and services received. If eligible, the claim will be processed for payment at currently authorized rate subject to any required deductibles.
7. Payment will be by electronic funds transfer (EFT) unless other arrangements have been made.
8. For assistance in completing the form, call 1-877-222-VETS (8387)

The Paperwork Reduction Act of 1995 requires VA to notify you that this information collection is in accordance with the clearance requirements of Section 3507 of this Act. We anticipate the time expended by individuals who must complete this form will average 3 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form. No person will be penalized for failing to furnish this information if it does not display a currently valid OMB control number. This information is collected under 38 CFR 70 and is intended to fulfill the need for Veterans and beneficiaries to claim Beneficiary Travel benefits and for VA to determine the individual's eligibility for the benefit.

Privacy Act Information: VA is asking you to provide the information on this form under 38 U.S.C. Sections 111 to determine your eligibility for Beneficiary Travel benefits and will be used for that purpose. Information you supply may be verified through a computer-matching program. VA may disclose the information that you put on the form as permitted by law; possible disclosures include those described in the “routine use" identified in the VA systems of records 24VA19 Patient Medical Record-VA, published in the Federal Register in accordance with the Privacy Act of 1974. Providing the requested information is voluntary, but if any or all of the requested information is not provided, it may delay or result in denial of your request for benefits. Failure to furnish the information will not have any effect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify Veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.