

Medical Mileage Reimbursement Request Form

Employer Name																								
Participant First Name MI Last Name																								
Add	ress											_												
City													1		State Zip C					ode				
Email Address																								
Soci	ocial Security Number / Member ID Phone Number																							
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Patient Name					Date Servi		Destination			L	Type of Service						Tot Mil		_		Amount to Reimburse *			
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											☐ Medical ☐ Vision ☐ Dental ☐ OTC ☐ Rx								\$	\$	\$			
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											☐ Medical ☐ Vision ☐ Dental ☐ OTC ☐ Rx								\$	\$	\$			
* Mu	ltiply ti	he "Tot	al Mil	es" by	the "M	Iileage	e Rate'	' to ge	t the "Æ	Amour	ıt to R	eimbu!	ırse"		To	tal A	mou	nt F	Reque	sted:	\$			

To Receive reimbursement for medical mileage:

- Medical mileage rates are set annually by the IRS. The current rate is found on your www.myebsaccount.com home page.
- Use this form to track mileage, calculate the mileage reimbursement amount and file a claim for expense reimbursement for transportation primarily for and essentially to medical care.
- Use one row for each round trip.
- Upon request, be able to produce documentation related to the

mileage expense you are claiming. For example, if you are claiming round-trip mileage to a doctor's appointment, you must have copies of receipts or statements pertaining to that visit and be able to supply these copies to EBS-RMSCO, Inc. if requested.

- Please be sure to provide your SSN or Member ID.
- Mail Claims to EBS-RMSCO, Inc., FSA Dept, PO Box 2330, Blasdell, NY 14219; Fax # (877) 256-7228.
- Call Customer Service with questions at 800-327-7130.

By submitting this form to EBS-RMSCO, Inc., I certify that the information here is true and correct, that the expenses incurred were for myself, spouse or qualified dependents and that these expenses are not reimbursable under any other plan coverage.