MEDICAL MILEAGE REIMBURSEMENT AND
MEDICAL-RELATED TRAVEL EXPENSE REIMBURSEMENT

Name of Insured: _____

Claim #: _____ Date of Incident: _____

MEDICAL MILEAGE CALCULATION

DATE	TREATING PROVIDER/ADDRESS	MILEAGE	PARKING/TOLLS

TOTAL MILES: _____ **TOTAL PARKING/TOLLS:** _____

MEDICAL-RELATED TRAVEL EXPENSES

_____

_____

TOTAL EXPENSES: _____

_____
Signature of Applicant