MILEAGE REIMBURSEMENT REQUEST FORM

EMPLOYEE:
EMPLOYER: University of Minnesota (1546)
DATE OF INJURY:
CLAIM NUMBER:

ADJUSTER:
FAX #: (952)826-3889
DIRECT PHONE:

Date	Name of Medical Facility	Round-trip Miles

I hereby certify or affirm that the above mileage was incurred by me as necessary travel related to my above-referenced workers' compensation Claim.

_____ _____
EMPLOYEE SIGNATURE DATE

Sedgwick CMS P O Box 14454 Lexington, KY 40512

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