MEDICAL MILEAGE & PARKING REIMBURSEMENT REQUEST FORM

Employee: ________________________ Date of Accident:__________________________

Employer: _________________________ Claim Number/SSN: _______________________

Date of Service	Name & Address of Medical Provider	Round Trip Mileage	Parking Fees (attach Receipts)
	Total		

Please understand that you have only one year after the date of service by a medical provider to submit your request for mileage and parking reimbursement, otherwise it will not be paid by the insurance company, in accordance with the Official Code of Georgia

Annotated § 34-9-203(c)(4).

Total Miles: __________ x $.40 per mile=$_________+ Parking $ _________= Total: $__________

____________________ ________________________________

DATE SIGNATURE