MILEAGE REIMBURSEMENT REQUEST

GENERAL INFORMATION AND INSTRUCTIONS

1. Employees injured as a result of a work related injury may be eligible for mileage reimbursement for trips to authorized medical providers.

2. The authorized medical treatment must be rendered at a place outside of the local or metropolitan area from the employee's principal place of employment.

3. Employees should complete Section 1 and then present this form to the medical provider for completion of Section 2. Employees may turn the completed form in to their state agency or mail or fax it directly to the CARO office for consideration.

Questions may be directed to the CARO office.

TO BE COMPLETED BY EMPLOYEE

PLEASE PRINT EMPLOYEE NAME AND ADDRESS

CAHO NO.

DATE OF INJURY

AGENCY

DATES OF TRAVEL

FROM (CITY)

TO (CITY)

NUMBER OF MILES ROUND TRIP

EMPLOYEE SIGNATURE

TO BE COMPLETED BY MEDICAL PROVIDER

WE HEREBY CONFIRM THE ABOVE-STATED EMPLOYEE WAS RENDERED MEDICAL TREATMENT AT

______________________________

(NAME OF MEDICAL PROVIDER)

ON THE DATES AS SPECIFIED

ADDRESS OF MEDICAL PROVIDER

CITY

STATE

ZIP

AUTHORIZED SIGNATURE

DATE

TO BE COMPLETED BY CARO

TOTAL MILES X __________ = $____________

APPROVED

DATE

MD JDD 07/26/21 (7-06)