CLAIM FOR MILEAGE REIMBURSEMENT

Name:
Address:

SSN:
DOA:
CLAIM #:

NAME OF DOCTOR OR MEDICAL FACILITY	DATE	MILES	PURPOSE OF VISIT

Any person who, knowingly and with intent to injure, defraud or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of a felony of the third degree.

_____ Signature of Employee

_____ Date Signed

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