MILEAGE CLAIM REIMBURSEMENT FORM

DATE:_____ INSURED: _____ CLAIM NO. _____

TO: _____
_____
_____
_____

PLEASE COMPLETE THE FOLLOWING INFORMATION BELOW FOR MILEAGE CLAIM:

DATE OF TRAVEL	Name of Medical Facility (excluding Pharmacies)	ROUND TRIP MILEAGE To & From Residence
	Total Mileage for this Sheet	

Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement incomplete, of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree FS 817.234(1)(b)

Client's Signature _____ Today's Date _____