Mileage Request Form

I hereby certify that this claim is true and correct. Name: _____

T.C.A. 50-6-204(a)(6)(A) provides that "when an injured worker is required by the worker's employer to travel to an authorized medical provider or medical facility located <u>OUTSIDE OF</u> a radius of fifteen (15) miles <u>(ONE WAY)</u> from such insureds residence or workplace, then upon request such employee shall be reimbursed for reasonable travel expenses, as measured from the employee's residence or workplaces to the location of the medical provider's facility." Effective January 1, 2025 the reimbursement rate is $.70 per mile by the Department of Finance and Administration.

DATE		START LOCATION (HOME OR WORK)	END LOCATION (MEDICAL PROVIDER OR FACILITY NAME)	MILES ROUNDTRIP

Total Number of Miles:

Please forward to your Claims Representative