MEDICAL TRAVEL EXPENSE FORM

Claim Number:	
Date of Injury:	
Claimant's Name:	
Claimant's address:	
City, State & Zip:	
Employer's Name:	
Today's Date:	
SIGNATURE:	

You are entitled to reimbursement of medical travel expenses incurred because of your industrial injury. Complete the appropriate boxes below. Copies of supporting documents should be attached, for example: parking, cab, toll receipts. The law does not permit reimbursement for mileage to/from a pharmacy or visiting your attorney.

This form may be photocopied as necessary. You should keep a copy for your records. For additional information visit our website at: www.bsglaw.com

DATE	**TRAVELED FROM** (Include Address, i.e home, work)	**TRAVELED TO** (Include name & address of medical provider)	**ROUND TRIP MILEAGE**	**PARKING (include receipt)**	**BRIDGE TOLLS** (include receipt)	**PUBLIC TRANS./ OTHER** (Include Receipts)
EXAMPLE 1/5/99	**HOME-5151 Maple St Anytown, MD**	**Dr. J. Smith 318 Main Street, Anytown, MD**	**8 miles**	**$1.50**	**$2.50**	**$5.00**
TOTAL				**$**	**$**	**$**