MILEAGE REIMBURSEMENT CLAIM FORM

*TO EXPEDITE YOUR CLAIM PROVIDE ALL MAPS AND DISTANCE INFORMATION

EMPLOYER: _____

EMPLOYEE NAME: _____ SS#_____ _____ _____

MEDICAL TRAVEL EXPENSES

DATE OF TRAVEL (SERVICE DATE OF CLAIM)	NAME OF FACILITY (PROVIDER NAME)	TOTAL MILES TRAVELED	MILEAGE RATE	TOTAL TO BE REIMBURSED
NOTES:			**TOTAL:**	

MILEAGE RATES: $0.205 PER MILE FOR 1/1/26-6/30/26 7/1/26-12/31/26 $0.235 PER MILE

PLEASE MAKE SURE ALL MILEAGE BEING SUBMITTED HAS PROPER DOCUMENTATION ON FILE WITH GMR OR SUBMITTED WITH THE CLAIM. DOCUMENTATION MUST INCLUDE PATIENT NAME AND DATE OF SERVICE.

The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Company's Cafeteria Plan with respect to such expenses and that medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state or city income tax on amounts paid from the Plan which relate to such expense.

_____ Signature

_____ Date

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