Dear Associate,

Florida workers’ compensation law provides for the reimbursement of mileage expenses to and from your workers’ compensation related medical appointments. To recoup your mileage expenses for doctor, therapy, or hospital treatment, please record the following: **(*please print)***

|  |  |
| --- | --- |
| Name:   | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Insured:   | The School Board of Brevard County\_\_\_  |
| Soc. Sec. No.:   | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Date of Acc:   | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Claim No.:   | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

|  |  |  |
| --- | --- | --- |
| Date   | Name of Doctor, Hospital, Therapist  | Number of miles driven round trip  |
| \_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| \_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| \_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| \_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| \_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| \_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| \_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| \_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| \_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

Unless you are at work, mileage begins from your home address to the medical facility and return.

To receive your reimbursement, this form must be submitted to your Workers’ Compensation Adjuster. You may reach your adjuster Claudia Waldecker by calling Sedgwick CMS 901-375-5098 or Stacey Bryan 901-566-3338.  When you desire a mileage reimbursement, make a photocopy of this form for your records, and then forward this sheet to “Sedgwick CMS, P.O. Box 14434, Lexington, KY 40512 or you may fax it to (407) 833-4111.  If you have any questions or your adjuster does not respond to your telephone calls, feel free to reach Risk Management for further information.

If you run out of space to list your mileage on this form gather the same information listed above on a separate sheet of paper and submit it to Sedgwick CMS.  Remember to include your name, social security number, and date of accident or claim number if known.

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

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_