Alabama Retail Comp
PO Box 240549 • Montgomery, AL 36124
(t) (800) 239-5423 • (f) (334) 263-1976
claims@alabamaretail.org
alabamaretailcomp.org

WORKERS' COMPENSATION CLAIM MILEAGE REIMBURSEMENT FORM

Claimant Name: ______________________ Claim No.: ____________

Home Address: ______________________
Street Address

______________ ______________ ______________
City State Zip

Appointment Date	Doctor's Name / Doctor's Address	Please Check One	Roundtrip Mileage
Appointment Date	Doctor's Name:	Traveled From: Home ☐ Work ☐	Roundtrip Mileage
	Doctor's Address:	Returned To: Home ☐ Work ☐	
Appointment Date	Doctor's Name:	Traveled From: Home ☐ Work ☐	Roundtrip Mileage
	Doctor's Address:	Returned To: Home ☐ Work ☐	
Appointment Date	Doctor's Name:	Traveled From: Home ☐ Work ☐	Roundtrip Mileage
	Doctor's Address:	Returned To: Home ☐ Work ☐	
Appointment Date	Doctor's Name:	Traveled From: Home ☐ Work ☐	Roundtrip Mileage
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Appointment Date	Doctor's Name:	Traveled From: Home ☐ Work ☐	Roundtrip Mileage
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Appointment Date	Doctor's Name:	Traveled From: Home ☐ Work ☐	Roundtrip Mileage
	Doctor's Address:	Returned To: Home ☐ Work ☐	

By signing below, I certify the above request for mileage is true and correct.

Signature: ______________________ Date: ____________

Return the completed form to the address above or claims@alabamaretail.org.