



## MILEAGE REIMBURSEMENT FORM

Claimant's Name: \_\_\_\_\_ Claim: \_\_\_\_\_

All reimbursement requests must be filed within one year of the date of incurred expense to be eligible for reimbursement.

Please Check One			
Appointment Date	Doctor's Name:	Traveled From: Home <input type="checkbox"/> Work <input type="checkbox"/>	Roundtrip Mileage
	Doctor's Address:	Returned To: Home <input type="checkbox"/> Work <input type="checkbox"/>	
Appointment Date	Doctor's Name:	Traveled From: Home <input type="checkbox"/> Work <input type="checkbox"/>	Roundtrip Mileage
	Doctor's Address:	Returned To: Home <input type="checkbox"/> Work <input type="checkbox"/>	
Appointment Date	Doctor's Name:	Traveled From: Home <input type="checkbox"/> Work <input type="checkbox"/>	Roundtrip Mileage
	Doctor's Address:	Returned To: Home <input type="checkbox"/> Work <input type="checkbox"/>	
Appointment Date	Doctor's Name:	Traveled From: Home <input type="checkbox"/> Work <input type="checkbox"/>	Roundtrip Mileage
	Doctor's Address:	Returned To: Home <input type="checkbox"/> Work <input type="checkbox"/>	
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	Doctor's Address:	Returned To: Home <input type="checkbox"/> Work <input type="checkbox"/>	
Appointment Date	Doctor's Name:	Traveled From: Home <input type="checkbox"/> Work <input type="checkbox"/>	Roundtrip Mileage
	Doctor's Address:	Returned To: Home <input type="checkbox"/> Work <input type="checkbox"/>	

I certify the above request for mileage is true and correct.

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

Please return the completed form to the address in the letterhead or [claims@alabamaretail.org](mailto:claims@alabamaretail.org).