



# Mileage Reimbursement Request

Employee Name/ID#: \_\_\_\_\_ Employee Phone: \_\_\_\_\_

Participant Name: \_\_\_\_\_ Date Submitted: \_\_\_\_\_

***Please review the following before submitting reimbursement request:***

- Mileage reimbursement must be approved in the plan.
- Mileage is not reimbursed for transportation to/from medical appointments or out of state travel.
- A spouse or parent of a minor is ineligible for mileage reimbursement.
- Mileage will be reimbursed at the [current federal reimbursement rate](#).

Date	From	To	Purpose of Travel	Miles
<b>Total Miles</b>				
<b>Reimbursement Rate</b>				\$
<b>Total Reimbursement</b>				\$

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Participant/Representative Signature

\_\_\_\_\_  
Date