

ITEMIZED STATEMENT OF CHARGES FOR TRAVEL

IC File # _____

Emp. Code # _____

Carrier Code # _____

Carrier File # _____

Employer FEIN _____

The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act

Employee's Name _____	Employee's Name _____ Telephone Number () - _____
Address _____	Employer's Address _____ City _____ State _____ Zip _____
City _____ State _____ Zip _____	Insurance Carrier _____
Home Telephone () - _____	Carrier's Address _____ City _____ State _____ Zip _____
Work Telephone () - _____	() - _____ () - _____
Social Security Number _____ Sex <input type="checkbox"/> M <input type="checkbox"/> F Date of Birth / / _____	Carrier's Telephone Number _____ Fax Number _____

Employees are entitled to reimbursement of **\$0.51** per mile for travel for medical treatment, provided they travel 20 miles or more roundtrip, starting January 1, 2011. (The mileage rate is **\$0.50** for 2010; **\$0.55** for 2009; **\$0.585** for July 1-December 31, 2008; **\$0.505** for January 1-June 30, 2008; **\$0.485** for 2007; **\$0.445** for January 18-December 31, 2006; and **\$0.31** for travel before that date.) Special consideration will be given to employees who are totally disabled. No reimbursement is allowed for trips to purchase medications or supplies unless medically necessary. These items must be purchased on visits to medical providers (G.S. §97-25).

DATE	NAME OF MEDICAL PROVIDER	CITY	TOTAL MILES ROUNDTRIP
/ /			
/ /			
/ /			
/ /			
/ /			
OTHER EXPENSES	If overnight stay is necessary, the following items will be approved as submitted. (Receipts must be furnished for carrier's file.)	Total motel expense (\$45.00 per day):	Total Miles:
		Total meal expense (\$6.00 Breakfast, \$8.00 Lunch, and \$14.00 Dinner):	X [mileage rate]*
		Total parking & cab expense (actual charge):	Other expenses:
		Total for other expenses:	Total all expenses:

*The mileage rate is **\$0.51** for travel, starting January 1, 2011; **\$0.50** for 2010; **\$0.55** for 2009; **\$0.585** for July 1 to December 31, 2008; **\$0.505** for January 1 to June 30, 2008; **\$0.485** for 2007; **\$0.445** for January 18 to December 31, 2006; and **\$0.31** for travel before that date.

I hereby certify that I have incurred all expenses listed above as a result of my workers' compensation injury.

Employee signature

Carrier's approval

Employee:

Mail your bill in duplicate promptly to employer and/or insurance carrier

Employer or Carrier/Administrator:

Travel may be reimbursed directly to the employee. It is not necessary to submit bills to the Commission for approval. Pay and retain copy in carrier's file.