

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 _____

Employer's Name _____ Telephone Number _____

Address _____

Employer's Address _____ City _____ State _____ Zip _____

City _____ State _____ Zip _____

Insurance Carrier _____

Home Telephone _____ Work Telephone _____

Carrier's Address _____ City _____ State _____ Zip _____

Social Security Number _____ Sex M F Date of Birth _____ / _____ / _____

Carrier's Telephone Number _____ Fax Number _____

Employees are entitled to reimbursement of **\$0.485** a mile for mileage traveled for medical treatment in workers' compensation cases, providing they travel 20 miles or more roundtrip on or after January 1, 2007. (The mileage rate is **\$0.445** for mileage traveled from January 18 to December 31, 2006, and **\$0.31** for mileage traveled 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 rate per mile is **\$0.485** for mileage traveled on or after January 1, 2007, **\$0.445** for mileage traveled from January 18 to December 31, 2006, and **\$0.31** for mileage traveled 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.