

REQUEST FOR MILEAGE REIMBURSEMENT

RE: Workers' Compensation Claim
Program: ACCA-WCSIF
Claim #:
Claimant:
Employer: Baldwin County Commission
D/A:

Instructions: Please complete this form monthly and return it to the address listed below for reimbursement. All mileage will be verified before it is reimbursed.

Date of Trip	Reason (Name of Doctor)	From (City, zip)	To (City, zip)	Mileage (Round Trip)

**Return by Mail to: CRS, Inc., P.O. Box 589, Montgomery, AL 36101-0589 or by Fax to: (334) 394-3244.
Mileage information may be emailed to ksievers@countyrisk.org.**