Chesapeake Employers Insurance™
Your workers' compensation specialist

MEDICAL TRAVEL EXPENSE FORM

You are entitled to reimbursement of travel expenses for medical treatment resulting from your work related injury. Complete appropriate boxes below, sign and date form and send to Chesapeake Employers' Insurance Company (Chesapeake Employers) at the address noted. For your records, be sure to copy all completed expense forms submitted to Chesapeake Employers.

Copies of supporting documents should be attached (ie., toll cab, and parking receipts)

All mileage bills are to be submitted monthly and will be paid at the applicable rate

This form may be copied for future use

Mail To: Chesapeake Employers' Insurance Company
PO Box 42377
Towson, MD 21284

(Please print for correct processing)

Claimant's First Name _____ Middle Initial _____ Last Name _____

Social Security No: ____ / ____ / ____ Date of injury: ____ / ____ / ____

Claim Number: _____ Claimant's phone number: (____) _____ - _____

Claimant's street address: _____

City: _____ State: _____ Zip Code: _____

DATE	TRAVELED FROM (Include Address)	TRAVELED TO (Include name and address of doctor, hospital, therapist, etc.)	ROUND TRIP MILEAGE	PARKING (Include Receipts)	BRIDGE TOLLS (Include Receipts)	PUBLIC TRANS/OTHER (Include Receipts)
Example 1/5/04	Home: 5151 Maple St. Anytown, MD	Dr. J.Smith 318 Main St. Anytown, MD	8 Miles	$1.50	———	———

This is a true and accurate account of my expenses. Such expenses were incurred for medical travel as a result of my work related injury only; miscellaneous unrelated travel expenses have been excluded from the total. I am aware that it is against the law for any person to knowingly misrepresent any fact in order to obtain workers' compensation benefits. **I hereby swear and affirm under the penalties of perjury that the facts listed above are true and correct to the best of my knowledge.**

Total Miles		X =	→ $
Total Parking		$	→ $
Total Bridge Tolls			$
Total Public Transportation/Other			$
Reimbursement			$

Employer:
Employer's Address:
Employer's Phone#

Date: _____ Signature of Injured Worker: _____

Chesapeake Employers will not issue reimbursement without this form and proof of visit from the medical provider's office.

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