Mileage Report

Employee Name: _____ **Our Claim #** _____

Date Traveled	Starting Location	Ending Location	Name of Doctor or Facility	Total Miles
			TOTAL MILES	

I confirm that I have traveled for treatment of my workers' compensation injury as shown above. I request reimbursement for the mileage.

_____

Signature Date

Mail to: Mississippi Public Entity Workers' Compensation Services
P.O. Box 22729
Jackson, MS 39225