MILEAGE REIMBURSEMENT

Official Use Only Rev 5/5/17

Mail To: **State Self Insurance Fund**
900 SW Jackson, Room 951-S
Landon State Office Building
Topeka, Kansas 66612-1251
FAX: 785-296-6995
PHONE: 785-296-2364

NAME:

HOME ADDRESS:

CITY: **STATE, ZIP:**

EMPLOYEE ID# :

Submit your mileage for all trips that exceed 5 miles round trip. The purpose of the trip must be for medical care for your injury or to purchase medically related items, such as prescriptions. Please submit this mileage request and any toll fee receipts on a monthly basis until your claim is closed.

DATE:	TOTAL MILES:	(Enter exact address) FROM WHAT LOCATION:	(Enter exact address) TO WHAT	PURPOSE OF TRIP: