



# Travel Reimbursement Request

- **Read the instructions on the back before you start.**
- **Independent Medical Examination travel? Ask us for the IME travel form (F245-224-000).**

**Worker Information (Please print)**

		Claim No.
Name (Last, First, Middle Initial)		Date of injury
Home address (not PO Box)	Apt #	Social Security No. (for ID only)
City	State	ZIP
		Phone no.

**Reason for travel: (check one)**

- Medical visit or treatment
- Vocational services
- Attending retraining class (attach copy of Transportation Encumbrance form)

**Travel Information – Instructions and example on back.**

A. Date (each trip) mm/dd/yyyy	B. Travel code (one per line - see back of form)	C. From (city where you lived)	D. To (city)	E. Provider name & reason for visit	F. No. of miles (round trip)	G. Expense cost (one per line)
1.						
2.						
3.						
4.						
5.						
6.						
7.						

**Required: Signature of the person you saw.**

1. _____	5. _____
Date	Date
2. _____	6. _____
Date	Date
3. _____	7. _____
Date	Date
4. _____	

**Required: Worker's Signature**

These expenses are related to my workers' compensation claim and I have not been reimbursed for them. I understand it is a crime to submit information I know is false. I have read and understand the instructions on the back of this form.

Date	Worker name printed	Worker's signature
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## Instructions: complete each column.

- **Column A:** Date you traveled (one date per line).
- **Column B:** Use only one code per line. Codes are listed below.
- **Column C:** City where you lived on the day you traveled.
- **Column D:** City you traveled to.
- **Column E:** Provider you saw and reason for traveling.
- **Column F:** Total number of miles you traveled round trip.
- **Column G:** Dollar amount of each expense (food, lodging, fares, parking). Only one expense per line. Parking expenses under \$10 don't require a receipt. You must attach copies of all receipts. All receipts must be itemized and legible. No credit card slips.

## Travel codes

Expense	Medical services	Vocational services	Retraining
Private vehicle mileage	0401A	V0028	0301R
Parking	0402A	0402A	0302R
Bridge & ferry toll	0403A	0403A	0303R
Commercial transportation	0405A	0405A	0304R
Taxi	0414A	0414A	Contact your Voc Counselor
Lodging	0406A	0406A	Contact your Voc Counselor
Breakfast	0407A	0407A	Contact your Voc Counselor
Lunch	0408A	0408A	Contact your Voc Counselor
Dinner	0409A	0409A	Contact your Voc Counselor

## Signatures

**Medical visits:** The person you saw must sign to verify each visit date.

**Vocational and Retraining services:** Your Vocational Counselor must sign to verify each date you traveled.

**Worker's signature:** You need to sign the form for reimbursement.

## Example

	A. Date (each trip) mm/dd/yyyy	B. Travel code (one per line)	C. From (city where you lived)	D. To (city)	E. Provider name & reason for visit	F. No. of miles (round trip)	G. Expense cost (one per line)
1.	03/05/2009	0401A	Olympia	Seattle	Dr. Smith; post-op visit	120	
2.	03/05/2009	0402A					\$15.00

## Need more help or more information?

Go to [www.LNI.wa.gov](http://www.LNI.wa.gov) and click on Injured Worker or call 1-800-LISTENS.

Or check WAC 296-20-1103.

Need more forms? Go to [www.Lni.wa.gov](http://www.Lni.wa.gov) and click on Get a Form or Publication.