MEDICAL TRAVEL EXPENSE FORM

Claimant's Name:	
Street Address:	
City:	
State and Zip :	
Date of Injury:	

You are entitled to reimbursement of medical travel expenses incurred because of your industrial injury. Complete the appropriate boxes below. Copies of supporting documents should be attached, for example: parking, cab, toll receipts

This form may be photocopied as necessary. You should keep a copy for your records. For additional information visit our website at: www.bsg-llp.com

DATE	TRAVELED FROM (Include Address)	TRAVELED TO (Include name & address of medical provider)	ROUND TRIP MILEAGE	PARKING	BRIDGE TOLLS	PUBLIC TRANS./ OTHER (Include Receipts)
EXAMPLE 1/5/99	**HOME-5151 Maple St** Anytown, MD	Dr. J. Smith 318 Main Street, Anytown, MD	**8 miles**	**$1.50**	**$2.50**	$5.00
TOTALS				**$**	**$**	**$**