MILEAGE REIMBURSEMENT

Official Use Only Rev 5/2020

Mail To: **State Self Insurance Fund**
Mills Building, Suite 600
109 SW 9th Street
Topeka, Kansas 66612-1251
FAX: 785-296-6995
PHONE: 785-296-2364

NAME:

ADDRESS:

CITY: STATE, ZIP:

EMPLOYEE ID# :

Submit your mileage for all trips that exceed 5 miles round trip, if the purpose of the trip was to obtain medical care or 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 DESTINATION:**	**PURPOSE OF TRIP:**