Workers' Compensation Mileage Claim Form

Name: _____ **Date of Accident: _____**
Home Address:_____ **Social Security #:_____**
Home Phone:_____ **Employer:_____**

Date	List trip(s) taken such as home to doctor, home to hospital, identify doctor, pharmacy, hospital by name and address and return home		Round Trip Mileage
	Beginning Location Address	Ending Location Address	
		Total Mileage	

Please complete and mail to:

LUBA Workers' Comp
PO Box 98082
Baton Rouge, LA 70898-9082

I certify that the above information furnished by me is true and correct and based on such information hereby claim payment for the mileage indicated.

Signature:_____ **Date:_____**