NEW MEXICO MUTUAL

Mileage Reimbursement Form

NAME: _____ CLAIM NO:

ADJUSTER:

DATE	DOCTOR/OFFICE VISITED	START ADDRESS	END ADDRESS	NUMBER OF MILES ROUND TRIP (15 mi. or more one-way)

Our company reserves the right to investigate all mileage claims. Any mileage submitted under false pretenses may be subject to referral to the New Mexico Workers' Compensation Fraud Unit (Section 52-1-1.3). This form will not be accepted without your signature.

SIGNATURE OF CLAIMANT: _____ DATE: _____

IF YOU HAVE ANY QUESTIONS REGARDING TRAVEL OR TRAVEL REIMBURSMENT, OR NEED ADDITIONAL FORMS, PLEASE CONTACT YOUR ADJUSTER