HSLI

LHA TRUST FUNDS
WORKERS' COMPENSATION

Workers' Compensation Mileage Reimbursement Form

Claim #: Date of Injury:	Adjuster:
Employee's Name:	Employer's Name:
Physical Address:	Employee's Telephone #:

Date	Travel From (Provide street address)	Travel To (Provide street address)	Distance (Total Miles) Round Trip	Name of Medical Provider
		TOTAL MILES:		**Amount:**

Warning: Per L.R.S. 23:1208 of the Louisiana Workers' Compensation Statute, it shall be unlawful for a person, for the purpose of obtaining or defeating any benefit or payment under the provisions of this Chapter, either for himself or for any other person, to willfully make a false statement or representation. Penalties for violations include imprisonment, fines, and/or the forfeiture of benefits.

I HAVE READ & FULLY UNDERSTAND THE ABOVE. I certify that the above information furnished by me is true and correct and represents travel related to the treatment of my on-the-job injury.

Signature_____ **Date**_____