MILEAGE EXPENSE RECORD

RETURN TO:

OFFICE OF RISK MANAGEMENT
P O BOX 91106
BATON ROUGE, LA. 70821

CLAIMANT NAME: **CLAIM NUMBER:**

Date Traveled	Beginning Address	Name and Physical address of Medical Provider	Ending Destination Address	Round Trip Mileage

Total Miles x .52 per mile _____

I certify that the above mileage claim submitted is complete and true and accurate, and certify my compliance with the Louisiana Workers' Compensation Act.

Warning: Per LA. 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 payment under the provision 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.

SIGNATURE: _____

DATE: _____