Louisiana Workers' Compensation

Social Security Number

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Request for Reimbursement of Medically-Related Travel Expenses

DATE	DEPARTING ADDRESS	DESTINATION ADDRESS	MILEAGE
			 -
			<u>'</u>
<u> </u>			
Submitted B	y:		
		Total Mileage: =	
	Print Claimants Name		
		Mileage Rate: =	per mile
	Date	Payment Total =	
		,	