MILEAGE REIMBURSEMENT

NAME: _____

ADDRESS: _____

_____ ZIP _____

SOCIAL SECURITY #: _____
(Required)

Submit your mileage for all trips that exceed 5 miles round trip, if the purpose of the trip was to obtain medical care or purchase medically related items, such as prescriptions. Please submit this mileage request on a monthly basis until your file is closed.

DATE	MILES	DESTINATION

MAIL TO: **State Self Insurance Fund**
900 SW Jackson, Room 951-S
Landon State Office Building
Topeka, KS 66612-1251