



TRAVEL REIMBURSEMENT REQUEST

Washington Hospitals
 Workers' Compensation Program
 PO Box 19557
 Seattle, WA 98109

Injured Worker Information			Claim No.
Worker's name (Last, First, Middle Initial)			Date of injury
Worker's home address (not PO Box)		Apt #	Social Security No. (for ID only)
City	State	ZIP	Worker's Phone Number

Travel Information Why did you travel? If you check more than 1 box, you must use a separate form for each type of travel.

I traveled for a medical visit or to receive treatment
 I traveled to receive vocational services
 I traveled to receive retraining
 (Attach copy of Transportation Encumbrance form)

Read the instructions on the back of this form before you complete this section.

A Date (Each Trip or expense) (mm dd yyyy)	B One travel or expense code per line (from back of form)	C From: (city where you lived on travel date)	D To: (City)	E Provider seen and reason for visit	F Round Trip Mileage	G Mileage Cost (optional - see back)	H Expense costs as listed on back (one per line)
1.						\$	\$
2.						\$	\$
3.						\$	\$
4.						\$	\$
5.						\$	\$
6.						\$	\$
7.						\$	\$
Totals						\$	\$

Signature Requirements:

Signature of the person you traveled to see: 1) Medical Visits - the person you saw must sign to verify each date you traveled. 2) Vocational and Retraining services - your vocational counselor must sign to verify each date you traveled.

Date and authorizing signature of person visited	Date and authorizing signature of person visited	Date and authorizing signature of person visited
1. _____ Date	4. _____ Date	7. _____ Date
2. _____ Date	5. _____ Date	
3. _____ Date	6. _____ Date	

Worker's Signature (forms not signed will be returned)

These expenses are related to my worker's compensation claim and I have not been reimbursed for them. I understand it is a crime to submit information I know is false. I have read and understand the instructions on the back of this form.

Date	Worker's signature
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**Read these instructions carefully before you complete this form.
We can only reimburse you if your form is complete, correct, and signed.**

Important information

If you traveled for an Independent Medical Exam (IME), this is not the correct travel form. Please find IME travel form F245-224-000 on the L&I Web site (<http://www.LNI.wa.gov/IPUB/245-224-000.pdf>) or call Provider Hotline 1-800-848-0811.

Per RCW 51.36.020, Reasonable travel expenses for orthotic/prosthetic repairs or replacement are payable (except for hearing aids) after your claim is closed **if both of these conditions apply:**

- 1) The appliance was originally purchased by L&I or your self-insured employer; **and**
- 2) You travel on or after 6/12/08

NOTE: Other travel expenses are not payable when your claim is closed or you are on pension, unless requested by L&I or your self-insured employer.

For medical and treatment visits, travel expense is only payable when you must travel more than 10 miles each way (over 20 miles round trip) to the nearest point of adequate treatment*. Travel expense is not payable beyond the nearest point of adequate treatment, even if you prefer to seek treatment at another location.

- *The 10 mile rule is waived if L&I or your self-insured employer requested the exam, and for vocational appointments.
- Travel expenses are not payable for driving to the pharmacy to get prescriptions filled.
- You can search for L&I providers near you with Find-A-Doc: www.LNI.wa.gov/ClaimsIns/Claims/FindaDoc/

Per the travel WAC 296-20-1103:

- L&I must receive your travel voucher within 12 months from the date of travel to be considered for payment.
- Without approval from your claim manager in advance, you may not be reimbursed for travel expenses.

Completing the form

Injured Worker Information: Complete as indicated. Be sure to write your home address, **not PO Box**.

Travel Information: Check the box for the type of travel. Use a separate form for each type of travel.

Columns:

A - Date of trip or expense. Write only one date per line.

B - Codes on chart below are listed by travel type, for example if charging to drive your car to a doctor visit, write code 0401A.

Codes: If you traveled for	Medical Services	Vocational Services	Retraining
Private vehicle mileage	0401A	V0028	0301R
Parking**	0402A	0402A	0302R
Bridge & Ferry toll*	0403A	0403A	0303R
Commercial Transportation*	0405A	0405A	0304R
Taxi*	0414A	0414A	Contact Voc Counselor
Lodging*	0406A	0406A	Contact Voc Counselor
Breakfast*	0407A	0407A	Contact Voc Counselor
Lunch*	0408A	0408A	Contact Voc Counselor
Dinner*	0409A	0409A	Contact Voc Counselor

*Copy of **receipt required**, other restrictions may apply.

** Parking receipt required if \$10 or more

C - This must be the city where you lived on the date you traveled.

D - Name of the city you visited.

E - Write the name of the person you saw, and the reason for your visit (such as exam, PT, or vocational).

F - List the total number of miles you traveled round trip.

G - OPTIONAL¹ - List the total mileage charge by multiplying round trip miles times the department rate on the date of travel. Mileage rate can be found on the GSA website (www.gsa.gov/mileage), or call Provider Hotline 1-800-848-0811.

¹Department will calculate cost.

H - Write in the dollar amount of each expense on a separate line (food, lodging, fares, parking).

You must attach all receipts. It is recommended to send copies and keep the original receipts.

Signature requirements:

Medical Visits - The person you saw must sign to verify each visit date.

Vocational and Retraining services - Your Vocational Counselor must sign to verify each date you traveled.

Worker's signature - Travel will not be reimbursed unless form has the worker's signature.