MEDICAL MILEAGE REIMBURSEMENT REQUEST

Injured Person: _____ **Date of Loss:** _____ / _____ / _____

(Use this form to record mileage involved in trips to doctor, hospital, pharmacy, physical therapist, etc.)

Date of Visit	Destination	Reason for Visit	Total Mileage (Round Trip)

_____ **TOTAL ROUND TRIP MILES:** _____

Signature: **X 0.55 / Mile**

TOTAL DUE: _____

The undersigned hereby claims the following medical mileage as an allowable expense under MCL 500.3107(a).