MEDICAL TRAVEL EXPENSE FORM (2025)

You are entitled to reimbursement of travel expenses for medical treatment resulting from your work related injury. Complete appropriate boxes below, sign and date form, and send to IWIF at the address noted. For your records, be sure to copy all completed expense forms submitted.

Copies of supporting documents should be attached (i.e., toll cab, and parking receipts). All mileage bills are to be submitted monthly and will be paid at the applicable rate.

For submission after 10/01/2017, IWIF will only reimburse mileage submitted within the later of 12 months of the medical service or treatment, or when the claim for compensation was accepted or determined compensable by the Commission. The mileage reimbursement rate for 2025 is 0.70.

Mail To: Chesapeake Employers' Insurance
Attention: Medical Payment Dept.
P.O. Box 9899
Baltimore, Maryland 21284-9899

Claimant's First Name _____ Middle Initial _____ Last Name _____

Date of Injury: _____ / _____ / _____

Claim Number: _____ Claimant's phone number: (_____) _____ - _____

Claimant's street address: _____

City: _____ State: _____ Zip Code: _____

DATE	TRAVELED FROM (Include Address)	TRAVELED TO (Include name and address of doctor, hospital, therapist, etc.)	ROUND TRIP MILEAGE	PARKING	BRIDGE TOLLS (Include Receipts)	PUBLIC TRANS/OTHER
Example 1/5/2025	Home: 5151 Maple St. Anytown, MD	Dr. J.Smith 318 Main St. Anytown, MD	8 Miles	1.50	———	———

This is a true and accurate account of my expenses. Such expenses were incurred for medical travel as a result of my work related injury only; miscellaneous unrelated travel expenses have been excluded from the total. I am aware that it is against the law for any person to knowingly misrepresent any fact in order to obtain workers' compensation benefits. **I represent that the information listed above is true and correct to the best of my knowledge.**

Total Miles	0	X.70	→ $ 0.00
Total Parking		$ 0.00	→ $ 0.00
Total Bridge Tolls			$ 0.00 $ 0.00
Total Public Transportation/Other			$ 0.00
Reimbursement			$ 0.00

Employer:
Employer's Address:
Employer's Phone#

Date: _____ Signature of Injured Worker: _____

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