MILEAGE REIMBURSEMENT FORM

Claim Number:

Name: Employer: COLORADO STATE UNIVERSITY

Address: Carrier #:

DATE	FROM	DESTINATION	ROUND TRIP MILES	PURPOSE
TOTAL MILES THIS SIDE:				

I certify that the statements in the above schedule are true and correct in all respects; that payment of the amounts claimed herein has not and will not be reimbursed to me from any other sources; that travel performed for which reimbursement is claimed was performed by me for medical treatment and that no claims are included for expenses of a personal or political nature or for any other expenses not authorized by Workers' Compensation; and that I actually incurred or paid the operating expense of the motor vehicle for which reimbursement is claimed on a mileage basis. I am aware that I may be prosecuted for fraud if the information I have provided is falsely documented.

Signature: **Date:**

Total to be Reimbursed: Miles _____ @ .53 (cents) per mile = $_____ after 1/1/14

Miles _____ @ .52 (cents) per mile = $_____ after 1/1/13

Return to: CCMSI, P. O. Box 4998, Greenwood Village, CO 80155