MEDICAL TRAVEL EXPENSE REIMBURSEMENT REQUEST

Patient Name:	PEIA ID Number:
Address:	
City/State/Zip:	
Purpose of Travel:	

Date	Time	To	From	Miles
TOTAL MILES: (Mileage Reimbursed at Federal Rate)				

I certify that these costs incurred were in connection with medical care for myself or an eligible dependent, are true, accurate and actual, and do not reflect any costs or expenses reimbursed or to be reimbursed from any other source.

Policyholder's Signature **Date**

MAIL COMPLETED FORM TO:

UMR
PO Box 30541
Salt Lake City, UT 84130-0541

1-888-440-7342
Fax: 1-855-405-2189