# Mileage Reimbursement

Employee: _____ Claim Number: _____ Date of Injury: _____

Employee Address: _____ Agency: _____

**Please complete each section of this form for each day mileage reimbursement is being claimed. Allow 4 weeks for processing. Forms can be faxed, emailed or mailed back for processing to SEICTF at (334)223-6170, SEICTF.Email@finance.alabama.gov, or to PO Box 1390, Montgomery, AL 36102-1390. If you are an active state employee, payments will be processed through direct deposit.**

| **Name and address of Physician or Medical Facility** | **Date(s) of Service** (Six months or less) | **Beginning Address** | **Address of Final Destination after Appointment** | **Round Trip Miles** (Must be 50 miles or more) |
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I wish to be reimbursed for the above mileage. I understand the intentional reporting of false information will disqualify me from receiving further SEICTF benefits and could expose me to penalties or criminal charges. I certify the information to be correct to the best of my knowledge.

Claimant Signature: _____

Date: _____

*Revised 8/16/2017*

| FUND | DEPT | UNIT | OBJ | ACTV | FUNC |
|---|---|---|---|---|---|
| 0780 | 010 | 6480 | 1103 | 7802 | 0592 |