gente
Employee Benefits and HR Solutions
Strong relationships start here

122 Parish Drive
Wayne, NJ 07470

MEDICAL MILEAGE CLAIM FORM

Employer Name:_____

Employee Name:_____ _____ SS#: _X_X_X_-_X_X_-_____
Last First Last 4 Digits Only

New Address: _____

Email Address: _____

Date	Destination	Travel Purpose	Total Miles	Mileage Rate	Reimbursement
				Total Requested Reimbursement	

Instructions:

1. Effective January 1, 2016 through December 31, 2016 the mileage reimbursement rate is 19 cents per mile.
2. Eligible expenses include travel to and from your medical care provider with your health care claim.
3. Please use the worksheet above as your documentation indicating the number of miles traveled, date(s) of service, reason for travel and the provider's name and address.
4. If you are requesting reimbursement for parking as well as mileage, you must include a parking receipt which indicates date(s) of service and cost.
5. Send completed form and attached documentation to gente:
   Fax to: 973-694-2913 or email: claims@gente.solutions

I certify that the expenses listed above have been incurred by me and/or my dependent(s) and qualify for reimbursement and that these expenses will not be claimed as a deduction on my personal income tax return. In addition the expenses listed above have not been reimbursed and are not reimbursable under any other health plan.

_____ _____
Your Signature Date