

Mileage Reimbursement Request

To receive reimbursement for mileage, you must complete this form and **attach a copy of the bill** from the medical provider who treated you.

Please Print

Employee Name: _____ **SSN:** _____

Name and Address of Medical Provider	Date(s) Incurred	Miles (Total)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name and Address of Medical Provider	Date(s) Incurred	Miles (Total)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name and Address of Medical Provider	Date(s) Incurred	Miles (Total)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name and Address of Medical Provider	Date(s) Incurred	Miles (Total)
_____	_____	_____
_____	_____	_____
_____	_____	_____

I hereby certify that the information on this form is true and accurate and that I believe these expenses are eligible under my flexible spending account program. I have not and will not receive reimbursement from any other plan for these expenses. I understand that reimbursement of an expense is not a guarantee by either Nyhart or my employer that if audited, the IRS will allow this expense. If my claim is disallowed, I alone am responsible for interest, penalties, and taxes due as a result.

I authorize release of payment through my reimbursement account.

Employee Signature _____
Date

Employer Name Submit to: Flex Claim Reimbursement
Nyhart
8415 Allison Pointe Boulevard, Suite 300
Indianapolis, IN 46250-4205