STATE OF NEBRASKA #009006
MILEAGE REIMBURSEMENT FORM

NAME: _____

DATE OF INJURY: _____

CLAIM NUMBER (if known) _____

DATE	PROVIDER (NAME OF DOCTOR OR CLINIC)	PURPOSE (EXAM, PT, X-RAYS)	#MILES

_____ _____

Signature **Date**

Please return completed form to your claim handler via email, or send to:
Gallagher Bassett Services
10050 Regency Circle, Suite 300
Omaha, NE 68114
Phone: 402-972-4786
Fax: 402-972-4777