

NMSIF (800) 432-2036 FAX (505) 820-0670  
Mailing Address: P.O. Box 846 Santa Fe, NM 87504

## MILEAGE REIMBURSEMENT REQUEST

Name: \_\_\_\_\_ Claim Number: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Employer: \_\_\_\_\_ Adjuster's Name: \_\_\_\_\_

Return Form Via Mail or Fax: (505) 820-0670

	Date & Time of Appointment with Health Care Provider	Name, Address, and Phone Number of Health Care Provider	Number of Miles* (Round Trip)
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Total Miles: \_\_\_\_\_  
x .40

Mileage Reimbursement Requested (1): \$ \_\_\_\_\_  
Meals and Lodging\*\* Reimbursement Requested (2): \$ \_\_\_\_\_  
Total Reimbursement Requested (1) + (2): \$ \_\_\_\_\_

Signature: \_\_\_\_\_  
(Form must be signed before payment can be issued)

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

\*Mileage must be 15 miles or more **ONE WAY** from your residence or place of employment whichever place travel originates from.

\*\* Reimbursement request for lodging (not to exceed \$85.00 and only if at least two hours travel one way is required) and/or meals (not to exceed \$30.00 in a 24 hour period) must be accompanied by a receipt for proof of date and service provided.

**Under New Mexico Law, Any Person Who Knowingly Presents A False Or Fraudulent Claims For Payment Of A Loss Or Benefit Or Knowingly Presents False Information In An Application For Insurance Is Guilty Of A Crime And May Be Subject To Civil Fines And Criminal Penalties.**