North Carolina Industrial Commission

IC File #_____

ITEMIZED STATEMENT OF CHARGES FOR TRAVEL

Emp. Code #_____

The Use of This Form Is Required Under the Provisions of the Workers' Compensation Act

Carrier Code #_____

Employee's Name

Address

City State Zip

( ) - ( ) -
Home Telephone Work Telephone

Employer's Name ( ) - Telephone Number

Employer's Address City State Zip

Insurance Carrier

Carrier's Address City State Zip

( ) - ( ) -
Carrier's Telephone Number Fax Number

For 2022, employees are entitled to reimbursement of **$0.585** per mile for travel for medical treatment occurring **1/1/22 through 6/30/22** and **$0.625** per mile for travel for medical treatment occurring **7/1/22 through 12/31/22,** provided they travel 20 miles or more roundtrip. Special consideration will be given to employees who are totally disabled. No reimbursement is allowed for trips to purchase medications or supplies unless medically necessary. These items must be purchased on visits to medical providers (G.S. § 97-25).

DATE	NAME OF MEDICAL PROVIDER	CITY	TOTAL MILES ROUNDTRIP
/ /			
/ /			
/ /			
/ /			
/ /			

OTHER EXPENSES	If overnight stay is necessary, the following items will be approved as submitted. (Receipts must be furnished for carrier's file.)	Total motel expense incurred through 6/30/21 (actual, up to $71.20 per day for in-state or $84.10 per day out-of-state). Total motel expense incurred on or after 7/1/21 (actual, up to $78.90 per day for in-state or $93.20 per day out-of-state).		Total Miles:	
		Total meal expense incurred through 6/30/21 ($8.40 Breakfast, $11.00 Lunch, and $18.90 Dinner in-state or $21.60 out-of-state). Total Meal expense incurred on or after 7/1/21 ($9.00 Breakfast, $11.80 Lunch, and $20.50 Dinner in-state or $23.30 out-of-state). :		**X [mileage rate]***	
		Total parking & cab expense (actual charge):		Other expenses:	
		Total for other expenses:		Total all expenses:	

*Prior mileage rates are as follows: (a) $0.56 for 2021; (b) $0.575 for 2020; (c) $0.58 for 2019; (d) $0.545 for 2018; (e) $0.535 for 2017.

I hereby certify that I have incurred all expenses listed above as a result of my workers' compensation injury.

Employee signature

Employee:
Mail your bill in duplicate promptly to employer and/or insurance carrier

Carrier's approval

Employer or Carrier/Administrator:
Travel may be reimbursed directly to the employee. It is not necessary to submit bills to the Commission for approval. Pay and retain copy in carrier's file.

NOTICE TO INJURED EMPLOYEE:
THIS FORM SHOULD BE RETURNED TO THE CARRIER AT THE ADDRESS ABOVE FOR PAYMENT.

FOR ASSISTANCE, CALL:
N.C. INDUSTRIAL COMMISSION
MAIN TELEPHONE: ***(919) 807-2500***
HELPLINE: ***(800) 688-8349***

FORM 25T