

# ITEMIZED STATEMENT OF CHARGES FOR TRAVEL

IC File # \_\_\_\_\_

Emp. Code # \_\_\_\_\_

Carrier Code # \_\_\_\_\_

Carrier File # \_\_\_\_\_

Employer FEIN \_\_\_\_\_

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

Employee's Name \_\_\_\_\_

Employer's Name \_\_\_\_\_ Telephone Number ( ) - \_\_\_\_\_

Address \_\_\_\_\_

Employer's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Carrier \_\_\_\_\_

( ) - \_\_\_\_\_ ( ) - \_\_\_\_\_  
Home Telephone \_\_\_\_\_ Work Telephone \_\_\_\_\_

Carrier's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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

Employees are entitled to reimbursement of **\$0.545 per mile for travel for medical treatment, provided they travel 20 miles or more roundtrip, starting January 1, 2018.** 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 (actual, up to \$71.20 per day in-state or \$84.10 per day out-of-state):	Total Miles:
		Total meal expense (\$8.40 Breakfast, \$11.00 Lunch, and \$18.90 in-state or \$21.60 out-of-state Dinner):	<b>X [mileage rate]*</b>
		Total parking & cab expense (actual charge):	Other expenses:
		Total for other expenses:	Total all expenses:

\*Prior mileage rates are as follows: (a) **\$0.535** for 2017; (b) **\$0.54** for 2016; (c) **\$0.575** for 2015; (c) **\$0.56** for 2014; (e) **\$0.565** for 2013.

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

\_\_\_\_\_  
**Employee signature**

\_\_\_\_\_  
**Carrier's approval**

**Employee:**

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

**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**