State of Maine Office of Workers' Compensation

MAIL FORM TO: Office of Workers'

Compensation

114 SHS, AUGUSTA, ME 04333-0114

*You are entitled to mileage reimbursement pursuant to 39-A M.R.S.A. § 315 for attendance at Board hearings. You are entitled to expenses and fees incurred for medical treatment pursuant to 39-A M.R.S.A. § 206 or for attendance at Board appointed medical exams pursuant to 39-A M.R.S.A. §§ 312 or 611.

*Complete this form and attach receipts. <u>MAIL THE COMPLETED FORM WITH RECEIPTS TO: EMPLOYEE HEALTH & BENEFITS, WORKERS' COMPENSATION, 114 STATE</u> HOUSE STATION, AUGUSTA, ME 04333-0114. PLEASE KEEP COPIES FOR YOUR RECORDS. (PLEASE COMPLETE IN BLACK INK) CALL 207-624-7359 WITH QUESTIONS.

'If your travel costs or other expenses are not paid within 30 days, you may contact a Claims Resolution Specialist at the Workers' Compensation Board.															
NAME AND ADDRESS (PAYEE):								CLAIM NUMBER:							
								DOI:							
							VC#								
			<u>, </u>					_							
	EI	mployers are responsible TRANSPORTATIO	for comply	ing with Bo	oard Rules Chap	ter 5, Sect	on 1.10 and i	Boai	ra R	ules	s Chapter				
ROUND TRIP AUTOMOBILE OTHER							OTHER EXPENSES LODGING MEALS NON TRAVEL-RELATED								
					OTHER		Receipt				AL3	NON TRAVEL-REL	AILD		
							Required				Is Included				
				Receipts Required 0.44 (Parking, Tolls, Other)		quired			(Allowed \$6 breakfast, \$6 lunch, \$16 dinner)				Dessints Demvined		
				0.44	(Farking, Tons, Other)		\$120)	\$6 IUNCH			16 dinner)	Receipts Require	Receipts Required		
DATE	TRAVELED FROM	TRAVELED TO	MILES	AMOUNT	ITEM	AMOUNT	AMOUNT	в	L	D	AMOUNT	ITEM	AMOUNT		
										_					
											TOTAL CLAIMED				
								BALANCE DUE							
(SIGNATURE WCD F011 (re	OF TRAVELER) v. 2/2019)		(DATE)					١	WCD APPROVAL:						