Workers' Compensation
Mileage Reimbursement Request

Injured Worker: _____

Claim Number: _____

Date of Accident: _____

Employer: _____

DATE	TRAVEL FROM	TRAVEL TO	ROUND TRIP MILES

TOTAL MILES: 0

_____ _____

SIGNATURE **DATE**

Mail to: Ariel Third Party Administrators
Post Office Box 212159
Columbia, South Carolina 29221
Claims: (855)222-6369 or (803)365-0050 Fax: (803)365-00978