State Accident Fund
Mileage Reimbursement Form

Injured Worker Name: **Claim No:**
Home Address:
Employer: **Date of Accident:**

Mileage must be more than 10 miles round trip* *Mileage will not be paid for travel to the drug store
Rate: 01/01/01 - 06/30/06 = .345; 07/01/06 - 06/30/08=.445; 07/01/08 - 12/31/09 = .505;
01/01/10 – 12/31/10 =.50; 01/01/11 – 06/30/2012 = .505; 07/01/2012 – 12/31/2012 = .555
01/01/2013 – 12/31/2103 = .565; 01/01/2014 – 12/31/2014 = .56; 01/01/2015 – present = .575

Date of Trip	Please include the following: From: full address (street, city, state, zip code) To: full address of the facility/doctor (street, city, state, zip code)	Round Trip Miles	Rate	Total SAF use only
	From :To:			
	From :To:			
	From :To:			
	From :To:			
	From :To:			
	From :To:			
	From :To:			
	From :To:			
	From :To:			

Signature of Injured Worker: _____ Date:

Remit to: State Accident Fund Post Office Box 1166 Lexington, South Carolina 29171

For additional copies, please visit our website www.saf.sc.gov

State Fund will compare all submitted roundtrip mileage to MapQuest Driving Directions. It is recommended that you wait at least 30 days before submitting mileage so the proper documentation can be received from the Physician's office.

If this form is not completed in its entirety it will be returned.