**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**](http://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.**