Medical Travel Log

For reimbursement of medical travel expenses

Date of Travel:	Patient's Name:	Location of Physician or Treatment Facility:	Type of Treatment/ Diagnosis:	Number of Miles:	Total Reimbursement Amount:

I certify that the medical travel expense(s) listed above was incurred for transportation primarily for and essential to medical care for myself or an eligible dependent. The medical care was provided by a physician in a licensed hospital or medical facility and no element of personal pleasure, recreation or vacation was involved in the travel.

_____

Name of Participant (Please Print)

_____ _____

Signature of Participant Date