Travel Expense Request for Reimbursement Form

Employer Name: _____

Employee Name: _____

Last Four Digits of SSN: _____

Email Address: _____

Please read the Reimbursement Account Rules and Claim Filing Instructions before completing this claim.

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

Employee Signature: _____

Date: _____ /_____ /_____

Please complete attached Mileage Reimbursement and return both pages for reimbursement.

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Birmingham AL 35238-0968

support@awm.cc
Fax – 855.265.1830
Awm125.com

Mileage Worksheet

Mileage Worksheet

Enter your information in the appropriate columns below.

Date	Provider Name & Address	Type of Service (medical, dental, vision, prescription)	Number of Miles Traveled (x) Mileage Rate	Total Cost
			x $ 0.17	$ 0.00
			x $ 0.17	$ 0.00
			x $ 0.17	$ 0.00
			x $ 0.17	$ 0.00
			x $ 0.17	$ 0.00
			x $ 0.17	$ 0.00
			x $ 0.17	$ 0.00
			x $ 0.17	$ 0.00

Date	Provider Name & Address	Type of Service (medical, dental, vision, prescription)	Parking Cost	Total Cost
				$ 0.00
				$ 0.00
			Total Reimbursement Requested	$ 0.00

CERTIFICATION AND AUTHORIZATION: I certify that the information on this form is accurate and complete. I am requesting reimbursement for eligible deductible expenses incurred by myself or an eligible dependent while I was a participant in the plan. (Patient & Relationship is assumed to be Self unless otherwise indicated.) I have already received these products and services and confirm that by requesting reimbursement here that I have not and will not seek reimbursement of this expense from any other plan or party. If I am covered under more than one health care account, reimbursement will be made according to the payment order determined by those plans and as stated on the website. Use of this service indicates my acceptance of the User Agreement.

Signature _____ **Date** _____