REIMBURSEMENT FORM

Print and send to:
City of Eugene
c/o of CCMSI
PO Box 13189
Salem, Oregon 97309

Worker's Name	
Address	
City & Zip Code	
Claim #	

Mileage* (round trip)

DATE	MILES	DOCTOR/PROVIDER	DATE	MILES	DOCTOR/PROVIDER

If additional mileage, attach extra sheet

TOTAL MILES _____

Prescriptions and medical equipment (the original receipts for all prescriptions must be attached)

DATE	AMOUNT	MEDICATION	DATE	AMOUNT	MEDICATION

TOTAL $_____

_____ _____

Signature **Date**

***Mileage reimbursement rates:**
January 1, 2017 to December 31, 2018: 53.5¢ per mile
January 1, 2019 to December 31, 2019: 58¢ per mile
January 1, 2020: 57.5¢ per mile