EBS-RMSCO, Inc.
Employee Benefit Solutions

Medical Mileage Reimbursement Request Form

Employer Name

Participant First Name | MI | Last Name

Address

City | State | Zip Code

Email Address

Social Security Number / Member ID | Phone Number

Patient Name	Date of Service	Destination	Type of Service	Total Miles	Mileage Rate	Amount to Reimburse *
			❑ Medical ❑ Vision ❑ Dental ❑ OTC ❑ Rx		$	$
			❑ Medical ❑ Vision ❑ Dental ❑ OTC ❑ Rx		$	$
			❑ Medical ❑ Vision ❑ Dental ❑ OTC ❑ Rx		$	$
			❑ Medical ❑ Vision ❑ Dental ❑ OTC ❑ Rx		$	$
			❑ Medical ❑ Vision ❑ Dental ❑ OTC ❑ Rx		$	$
			❑ Medical ❑ Vision ❑ Dental		$	$
			❑ Medical ❑ Vision ❑ Dental ❑ OTC ❑ Rx		$	$
			❑ Medical ❑ Vision ❑ Dental ❑ OTC ❑ Rx		$	$
* *Multiply the "Total Miles" by the "Mileage Rate" to get the "Amount to Reimburse"*				Total Amount Requested:		$

To Receive reimbursement for medical mileage:

- Medical mileage rates are set annually by the IRS. The current rate is found on your www.myebsaccount.com home page.
- Use this form to track mileage, calculate the mileage reimbursement amount and file a claim for expense reimbursement for transportation primarily for and essentially to medical care.
- Use one row for each round trip.
- Upon request, be able to produce documentation related to the mileage expense you are claiming. For example, if you are claiming round-trip mileage to a doctor's appointment, you must have copies of receipts or statements pertaining to that visit and be able to supply these copies to EBS-RMSCO, Inc. if requested.
- Please be sure to provide your SSN or Member ID.
- Mail Claims to EBS-RMSCO, Inc., FSA Dept PO Box 22999, Rochester, NY 14692 .
- Call Customer Service with questions at 800-327-7130.

By submitting this form to EBS-RMSCO, Inc., I certify that the information here is true and correct, that the expenses incurred were for myself, spouse or qualified dependents and that these expenses are not reimbursable under any other plan coverage.