

REQUEST FOR REIMBURSEMENT OF EXPENSES FOR TRAVEL AND LOST WAGES

Pursuant to NRS 616C.365 and 616C.477

Claim No: _____

Date of Injury: _____

Insurer's Name: _____

Injured Employee's Name: _____ Social Security No. _____

Present Employer: _____ Phone No: _____

Date of Hearing/Treatment: _____

Time of Hearing/Treatment: Begin _____ End _____

From: Place of Employment Residence* (Check One) *DO NOT USE RESIDENCE FOR EXTENDED TRAVEL BENEFIT

Address: _____

To: Place of Hearing/Treatment: _____

Address: _____

FOR TRAVEL AND LOST WAGES FOR HEARINGS Pursuant to NRS 616C.365	
Total Miles Traveled (One Way)	FOR INSURER'S USE
Food	Miles X 2 X
Lodging	per mile =
Lost Wages	
Total Expenses	
	Total \$

LOST WAGES COMPENSATION FOR EXTENDED MEDICAL TRAVEL Pursuant to NRS 616C.477	
Employer at time of injury: _____	FOR INSURER'S USE
Total Miles Traveled (One Way)	Qualify? <input type="checkbox"/> YES or <input type="checkbox"/> NO
Total Time Absent from Employment	TTD <input type="checkbox"/> 50% or <input type="checkbox"/> 100 %
	TTD RATE \$

I declare under penalty of perjury that the above amounts were necessarily incurred and that they are true and correct to the best of my knowledge.

Date

Signature of Injured Employee