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

		FOR INSURER'S USE
Total Miles Traveled (One Way)	_____	Miles X 2 X
		per mile =
Food	_____	
Lodging	_____	
Lost Wages	_____	
Total Expenses	_____	Total $

LOST WAGES COMPENSATION FOR EXTENDED MEDICAL TRAVEL
Pursuant to NRS 616C.477

		FOR INSURER'S USE
Employer at time of injury:	_____	
Total Miles Traveled (One Way)	_____	Qualify? ☐ YES or ☐ NO
Total Time Absent from Employment	_____	TTD ☐ 50% or ☐ 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