North Carolina Industrial Commission

ITEMIZED STATEMENT OF CHARGES FOR TRAVEL

IC File #_____

Emp. Code #_____

Carrier Code #_____

Carrier File #_____

Employer FEIN _____

The Use of This Form Is Required Under the Provisions of the Workers' Compensation Act

Employee's Name	Employer's Name ( ) - Telephone Number
Address	Employer's Address City State Zip
City State Zip	Insurance Carrier
( ) - Home Telephone ( ) - Work Telephone	Carrier's Address City State Zip
	( ) - Carrier's Telephone Number ( ) - Fax Number

Employees are entitled to reimbursement of **$0.535** per mile for travel for medical treatment, provided they travel 20 miles or more roundtrip, starting January 1, 2017. Special consideration will be given to employees who are totally disabled. No reimbursement is allowed for trips to purchase medications or supplies unless medically necessary. These items must be purchased on visits to medical providers (G.S. §97-25).

DATE	NAME OF MEDICAL PROVIDER	CITY	TOTAL MILES ROUNDTRIP
/ /			
/ /			
/ /			
/ /			
/ /			

OTHER EXPENSES	If overnight stay is necessary, the following items will be approved as submitted. (Receipts must be furnished for carrier's file.)	Total motel expense ($45.00 per day):		Total Miles:	
		Total meal expense ($6.00 Breakfast, $8.00 Lunch, and $14.00 Dinner):		**X [mileage rate]***	
		Total parking & cab expense (actual charge):		Other expenses:	
		Total for other expenses:		Total all expenses:	

*Prior mileage rates are as follows: (a) **$0.54** for 2016; (b) **$0.575** for 2015; (c) **$0.56** for 2014; (d) **$0.565** for 2013; (e) **$0.555** for July 1, 2011 - December 31, 2012; (f) **$0.51** for January 1, 2011 - June 30, 2011; (g) **$0.50** for 2010; (h) **$0.55** for 2009; (i) **$0.585** for July 1, 2008 - December 31, 2008; (j) **$0.505** for January 1, 2008 - June 30, 2008; (k) **$0.485** for 2007; (l) **$0.445** for January 18, 2006 - December 31, 2006; and (m) **$0.31** for travel before January 18, 2006.

I hereby certify that I have incurred all expenses listed above as a result of my workers' compensation injury.

Employee signature

Carrier's approval

Employee:
Mail your bill in duplicate promptly to employer and/or insurance carrier

Employer or Carrier/Administrator:
Travel may be reimbursed directly to the employee. It is not necessary to submit bills to the Commission for approval. Pay and retain copy in carrier's file.

NOTICE TO INJURED EMPLOYEE:
THIS FORM SHOULD BE RETURNED TO THE CARRIER AT THE ADDRESS ABOVE FOR PAYMENT.

FOR ASSISTANCE, CALL:
N.C. INDUSTRIAL COMMISSION
MAIN TELEPHONE: ***(919) 807-2500***
HELPLINE: ***(800) 688-8349***

FORM 25T