

SC State Accident Fund
Mileage Reimbursement Form

Injured Worker Name:

Claim No:

Home Address:

Employer: Coastal Carolina University

Date of Accident:

***Mileage must be more than 10 miles round trip* *Mileage will not be paid for travel to the drug store* The current mileage rate is .575 per mile.**

Date of Trip	Please include the following: From: full address (street, city, state, zip code) To: full address of the facility/doctor (street, city, state, zip code)	Round Trip Miles	Rate	Total SAF use only
	From: To:			
	From: To:			
	From: To:			
	From: To:			
	From: To:			
	From: To:			
	From: To:			
	From: To:			

Signature of Injured Worker: _____ Date: _____

The South Carolina State Accident Fund will compare all submitted roundtrip mileage to MapQuest Driving Directions. It is recommended that you wait at least 30 days before submitting mileage so the proper documentation can be received from the Physician's office. If this form is not completed in its entirety, it will be returned.

Remit to: State Accident Fund Post Office Box 102100 Columbia, South Carolina 29221-5000 Attention:
 Larisa Benson or Rose Marie Johnson: Singleton 211