Travel Reimbursement Request
Instructions Sheet

Instructions: complete each column.

- **Column A:** Date you traveled (one date per line).

- **Column B:** Use only one code per line. Codes are listed below.

- **Column C:** City where you lived on the day you traveled.

- **Column D:** City you traveled to.

- **Column E:** Provider you saw and reason for traveling.

- **Column F:** Total number of miles you traveled round trip.

- **Column G:** Dollar amount of each expense (food, lodging, fares, parking). Only one expense per line. Parking expenses under $10 don't require a receipt. You must attach copies of all receipts. All receipts must be itemized and legible. No credit card slips.

Travel codes

Expense	Medical services
Private vehicle mileage	0401A
Parking	0402A
Bridge & ferry toll	0403A
Commercial transportation	0405A
Taxi	0414A
Lodging	0406A
Breakfast	0407A
Lunch	0408A
Dinner	0409A

Signatures
Medical visits: The person you saw must sign to verify each visit date.
Victim's signature: You need to sign the form for reimbursement.

Example

	A. Date (each trip) mm/dd/yyyy	B. Travel code (one per line)	C. From (city where you lived)	D. To (city)	E. Provider name & reason for visit	F. No. of miles (round trip)	G. Expense cost (one per line)
1.	03/05/2009	0401A	Olympia	Seattle	Dr. Smith; post-op visit	120	
2.	03/05/2009	0402A					$15.00

Need more help or more information?
Go to **www.lni.wa.gov/ClaimsIns/CrimeVictims** or call **1-800-762-3716.** Or check WAC 296-20-1103.

Independent Medical Examination travel? Or just need more forms?
Go to **www.lni.wa.gov/ClaimsIns/CrimeVictims** and click on Forms & Publications for Crime Victims

Travel Reimbursement Request

Victim Information (Please print)

Claim No.

Name (Last, First, Middle Initial)			Date of crime injury
Home address (not PO Box)		Apt #	Social Security No. (for ID only)
City	State	Zip	Phone no.

Travel Information – Instructions and example on next page.

	A. Date (each trip) mm/dd/yyyy	**B.** Travel code (one per line - see next page of form)	**C.** From (city where you lived)	**D.** To (city)	**E.** Provider name & reason for visit	**F.** No. of miles (round trip)	**G.** Expense cost (one per line)
1.							
2.							
3.							
4.							
5.							
6.							
7.							

Required: Signature of the person(s) you saw.

1.	Date	5.	Date
2.	Date	6.	Date
3.	Date	7.	Date
4.	Date	8.	Date

Required: Victim's Signature

These expenses are related to my victim's compensation claim and I have not been reimbursed for them. I understand it is a crime to submit information I know is false. I have read and understand the instructions on the next page of this form.

Date	Victim's name printed	Victim's signature