MEDICAL MILEAGE REIMBURSEMENT LOG

Patient Name: _____

Tax Year / Period: _____

Provider Name: _____

Vehicle Model/Year: _____

Date	Starting Location	Destination (Provider)	Medical Purpose / Reason	Start Odometer	End Odometer	Total Miles	Parking/Tolls ($)	Other Expenses ($)

Total Mileage:	
Mileage Rate:	
Total Mileage Reimbursement:	
Total Tolls/Parking/Other:	
Total Reimbursement Due:	

Patient / Claimant Signature Date

Approver Signature Date