

State of New York  
WORKERS' COMPENSATION BOARD  
**CLAIMANT'S RECORD OF MEDICAL AND TRAVEL EXPENSES  
AND REQUEST FOR REIMBURSEMENT**

|                     |                                |                     |
|---------------------|--------------------------------|---------------------|
| CLAIMANT'S NAME     | WCB CASE NO.                   | SOCIAL SECURITY NO. |
|                     |                                |                     |
| RESIDENTIAL ADDRESS | MAILING ADDRESS (IF DIFFERENT) |                     |
|                     |                                |                     |

In connection with the above workers compensation case, you are entitled to be reimbursed for (1) medications or supplies properly prescribed by your health care provider that you paid for yourself and for (2) fares, automobile mileage or other necessary expenses going to and from your health care provider's office or the hospital.

To help you keep a record of such expenses we have provided this form. In order to help insure that you are properly reimbursed, list each item of expense below -- whether or not you obtained a receipt (wherever possible obtain receipts). **Submit the completed form and copies of all receipts or bills to the workers' compensation insurance carrier (or to your employer, if self-insured) and to the Workers' Compensation Board.** (See Board address on reverse.) It is suggested that you retain a copy of the receipts and bills for your records.

| NATURE OF EXPENSE | DATE | AMOUNT |
|-------------------|------|--------|
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**Continue on Reverse.**

