Claim	Number:			
Empl	loyee Name:			
Employer Name:		Minneapolis College of Art and Design		
Date	of Injury:			
			_	
MEDICAL MILEAGE FORM				
DATE	FROM (Must be STREET address, city, state & z	TO (Must be STREET address, city, state & zip)	TOTAL MILES (Round Trip)	PURPOSE OF TRIP (i.e., doctor, therapy, etc. MUST include provider/Dr/facility name)
company, or se	elf-insured program, f ny of the third degree	h intent to injure, defraud, or cilling a statement of claim con. I certify that this is a true sta	taining any false	
Signed Employee Signature				
Submit mileage claim to: Citizens Insurance Company of America P.O. Box 15144 Worcester, MA 01615-0144				

OR, Fax to: (508) 926-5660