



Form Instructions

Please complete as much information as you have available. If you need help completing the form, contact Claims at (208) 332-2100 or (800) 334-2370.

Please save a copy for your records.

Submission options:

- **Upload** at <https://hub.idahosif.org/Document/Upload>
- **Email** as an attachment to: ClaimsIM@IdahoSIF.org
- **Mail to:**
SIF, Idaho Workers' Compensation
P.O. Box 83720
Boise, ID 83720-0044

Note: Mistakes happen, if you spot or realize an error, please contact us and we will work with you to sort things out. Please be aware that any person who knowingly, and with intent to defraud or deceive any insurance company, submits a statement or claim containing any false, incomplete, or misleading information is violating the law.

Reimbursement for Health Care Travel Expenses Form

Pursuant to Idaho Code 72-432(1)

Name of Injured Worker: _____

Claim #: _____

Address: _____

Phone: _____

1. Use this form when claiming reimbursement for travel expenses incurred while pursuing reasonable or necessitated diagnosis, treatment, or care of an industrial injury or occupational disease.
2. Only mileage in excess of fifteen (15) miles for any given round trip is reimbursable. However, you should report the total mileage for each round trip. You are expected to take the shortest practical route of travel.
3. Reimbursement shall be made at the mileage rate allowed by the State Board of Examiners for state employees. The current rate for this mileage is available through your insurance company or by contacting the Idaho Industrial Commission.
4. You must attach to this form a copy of a bill or receipt showing that each visit occurred.

Date of visit	Name of provider of health care services	Purpose of visit	Total mileage

(Please type or print neatly.)

Injured worker signature

Date signed

Date received by surety