Mileage Form for Care Wisconsin

EMPLOYEE NAME: _____ **DATE OF TRAVEL:** _____

TRIP 1:

ADDRESS TRAVELED TO: _____

ADDRESS TRAVELED FROM: _____

PATIENTS NAME:_____

BEGINNING MILEAGE:_____ENDING MILEAGE:_____

TOTAL MILEAGE TRAVELED: _____

TRIP 2:

ADDRESS TRAVELED TO: _____

ADDRESS TRAVELED FROM: _____

PATIENTS NAME:_____

BEGINNING MILEAGE:_____ENDING MILEAGE:_____

TOTAL MILEAGE TRAVELED: _____

TRIP 3 (If needed):

ADDRESS TRAVELED TO: _____

ADDRESS TRAVELED FROM: _____

PATIENTS NAME:_____

BEGINNING MILEAGE:_____ENDING MILEAGE:_____

TOTAL MILEAGE TRAVELED: _____

SUPERVISOR'S AUTHORIZATION: _____

EMPLOYEE SIGNATURE: _____

Please fax completed forms with your timecards to

877-375-2450 no later than 12:00 p.m. EST on Monday.