IOWA MUNICIPALITIES WORKERS' COMPENSATION ASSOCIATION

IMWCA

Medical Mileage Reimbursement Request

Employee: _____ Date of injury: _____

Employer: _____ Claim Number: _____

Medical Provider	Date of Treatment	Mileage (round trip)

Please fax or e-mail this completed form to (978) 367-2862 or imwcaclaims@iowaleague.org