Claimant's Record of Medical and Travel Expenses

CLAIMANT'S NAME	Last 4 of CLAIMANT'S SOCIAL SECURITY NUMBER xxx-xx-	CLAIMANT'S DATE OF BIRTH
WCB #	DATE OF ACCIDENT	CARRIER CASE NUMBER
CLAIMANT'S Mailing Address	CLAIMANT'S Phone number	CARRIER NAME & ADDRESS

Date	Office Visited	Address	Round Trip Miles	Mileage Rate	Reimbursement Requested	Amount Paid by Carrier	Reason full Amount requested not paid
1/1/25 EXAMPLE	Dr. John Smith EXAMPLE	1 Main St, Oneonta, NY 13820 EXAMPLE	10 miles EXAMPLE	$.70/mile EXAMPLE	$6.70 EXAMPLE	For Carrier Use	For Carrier Use
				TOTAL			

Modified C-257