Mileage Expense Certification Log

MANAGEMENT AND BUDGET
STATE EMPLOYEE GROUP INSURANCE PROGRAM

Employee Name

Employer

State of Minnesota

State of Minnesota Employee ID Number

This form may be used to itemize mileage expenses incurred for eligible medical, dental, and vision care appointments. The total from this page should be transferred to a completed and signed claim form, and included with your claim submission as supporting documentation.

Provider Name, Type of Service & Service Location	Treatment Dates *(MM/DD/YYYY)*	Person Receiving Service *(First and Last Name)*	# of Round Trip Miles Traveled	Mileage Expense*
				$.
				$.
				$.
				$.
				$.

Total *(transfer your total to your claim form and submit this with your claim form)* $.

*THE MILEAGE RATE FOR SERVICES PROVIDED:

From 1/1/24 - 12/31/24: (21 cents) x (# of miles)

From 1/1/23 - 12/31/23: (22 cents) x (# of miles)

CERTIFICATION AND AUTHORIZATION: By submitting this form, you certify that an amount equal to the amount set forth above was expended by you on the dates set forth above for mileage expenses incurred while traveling to/from a provider of eligible medical services.

SUBMIT THIS DOCUMENT WITH YOUR COMPLETED CLAIM FORM BY MAIL OR FAX:

MAILING ADDRESS: Benefit Resource, LLC | PO BOX 642 | Willow Grove, PA 19090
FAX: (877) 918-3622