Mileage Expense Certification Log

Employee Name

Employer

Member ID *(set by your employer. Typically an employee ID or SSN.)*

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.

WHAT YOU NEED TO KNOW:

- You may use this form to itemize mileage expenses necessary to obtain eligible medical care
- The total from this page must be transferred to a completed and signed claim form and this Mileage Log must be submitted with your claim form as supporting documentation.

SUBMIT THIS DOCUMENT WITH YOUR COMPLETED CLAIM FORM BY MAIL:

Benefit Resource, LLC | PO BOX 642 | Willow Grove, PA 19090