# Wabash County Cancer Society, Inc.

Mileage Statement for Reimbursement  Month _____  Year _____

Patient Name: _____  Address: _____

| Date of Departure | From (city) | To (city) | Name of Facility Where Service was Performed | Date of Service | Signature of Facility Representative (to confirm visit) | Date of Return | Round-trip Mileage |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

TOTAL MILEAGE: _____

Signature of Patient, Member of Patient's Family or Legal Guardian: _____

TO BE FILLED OUT BY DOCTOR: Type of service to patient at facility: _____

_____

DOCTOR'S SIGNATURE: _____  DATE: _____