SOUTHWEST RESEARCH INSTITUTE

FSA MILEAGE WORKSHEET

Enter your information in the appropriate columns below.

This reimbursement worksheet is for mileage expenses for travel to and from your doctor, dentist, pharmacy or other medical care provider. To be reimbursed for eligible mileage or parking expenses, document the required information on this form.

Date MM/DD/YY	Provider Name & Address	Type of Service (medical, dental, vision, prescription)	Number of Miles Traveled (x) Mileage Rate	Total Cost
			X $ 0.21	$ 0.00
			X $ 0.21	$ 0.00
			X $ 0.21	$ 0.00
			X $ 0.21	$ 0.00
			X $ 0.21	$ 0.00
			X $ 0.21	$ 0.00
			X $ 0.21	$ 0.00
			X $ 0.21	$ 0.00

Date MM/DD/YY	Provider Name & Address	Type of Service (medical, dental, vision, prescription)	Parking Cost	Total Cost
				$ 0.00
				$ 0.00
			Total Reimbursement Requested	$ 0.00

Please note: You must submit a Health Care Claim form along with the Mileage Worksheet Certification and Authorization statement that is signed and dated to be considered for reimbursement. A Mileage Worksheet submitted without a signed and dated Certification and Authorization statement will not be considered for reimbursement.

Beginning January 1, 2024, the IRS' standard mileage rate is 0.21 cents per mile for medical.

The IRS mileage rates can be found at https://www.irs.gov/tax-professionals/standard-mileage-rates.

CERTIFICATION AND AUTHORIZATION: I certify that the information on this form is accurate and complete. I am requesting reimbursement for eligible deductible expenses incurred by myself or an eligible dependent while I was a participant in the plan. I have already received these products and services and confirm that by requesting reimbursement here that I have not and will not seek reimbursement of this expense from any other plan or party.

Signature _____ Date _____