Mileage Worksheet

FSAFEDS participants can be reimbursed for mileage and parking 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 the form on the following page.

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.

For the 2021 benefit period, the mileage rate is 16 cents per mile. The deadline to submit mileage claims from the 2021 benefit period is April 30, 2022.

For the 2022 benefit period, the mileage rate is 18 cents per mile.

Example

Let's say you are sick and drive 18 miles each way to see a doctor on February 1. Then the following day, you drive to the local pharmacy to fill a prescription. Later in the month, you have your eyes checked and purchase new eyeglasses, which you pick up on February 22. The chart below shows how to log the mileage.

Date MM/DD/YY	Provider Name & Address	Type of Service (medical, dental, vision, prescription)	Number of Miles Traveled	Parking Cost or Mileage Rate	Total Cost
02 01 22	Dr. Goody 123 Main Street, Anytown 00000	Medical	36	$0.18	$6.48
02 01 22	Dr. Goody 123 Main Street, Anytown 00000	Parking	N/A	$15.00	$15.00
02 02 22	CVS 99887 Front Street, Anytown 00123	Prescription	15	$0.18	$2.70
02 08 22	Vision Center 456 Second St., Anytown 00456	Vision	5	$0.18	$0.90
02 22 22	Vision Center 456 Second St., Anytown 00456	Vision	5	$0.18	$0.90
				Total Reimbursement Requested	**$25.98**

Mileage Worksheet

Enter your information in the appropriate columns below.

Date MM/DD/YY	Provider Name & Address	Type of Service (medical, dental, vision, prescription)	Number of Miles Traveled (x) Mileage Rate	Total Cost
☐☐☐☐☐☐			X $ 0.18	$ 0.00
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☐☐☐☐☐☐			X $ 0.18	$ 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

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. (Patient & Relationship is assumed to be Self unless otherwise indicated.) 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. If I am covered under more than one health care account, reimbursement will be made according to the payment order determined by those plans and as stated on the website. Use of this service indicates my acceptance of the User Agreement. Log in to your FSAFEDS account to review the User Agreement.

Signature _____ Date _____