STATE OF ALABAMA

PUBLIC EDUCATION EMPLOYEE INJURY COMPENSATION BOARD (PEEICB)

PEEICB Form MR-1
(Rev. 2026)

MILEAGE REIMBURSEMENT REQUEST

SUBMIT COMPLETED FORM TO:

Millennium Risk Managers
c/o PEEICB
P.O. Box 382408
Birmingham, AL 35238
Email to: PEEICB@mrm-llc.com
Fax: 205-777-6097

Reimbursement request is for an on the job injury: ☐ YES ☐ NO

EMPLOYEE INFORMATION

Employee Name: _____

SSN / Employee ID (Last 4): _____

Mailing Address: _____

_____

City: _____ State: _____ ZIP: _____

Phone Number: _____ Email: _____

EMPLOYER / SCHOOL INFORMATION

School System / Employer: _____

School / Location: _____

Department / School: _____

Supervisor Name: _____

Supervisor Phone: _____

INJURY / CLAIM INFORMATION

Date of Injury: _____ Claim Number: _____

Have you received payment for this mileage from any other source? ☐ YES ☐ NO

If yes, explain: _____

MILEAGE LOG (Round Trip Mileage)

DATE (mm/dd/yyyy)	MEDICAL PROVIDER / FACILITY (Doctor, Hospital, Clinic, Therapy, etc.)	FROM (Starting Location)	TO (Destination)	PURPOSE OF VISIT (Check One)	ROUND TRIP MILES
1.				☐ Treatment ☐ Test ☐ Other	
2.				☐ Treatment ☐ Test ☐ Other	
3.				☐ Treatment ☐ Test ☐ Other	
4.				☐ Treatment ☐ Test ☐ Other	
5.				☐ Treatment ☐ Test ☐ Other	
6.				☐ Treatment ☐ Test ☐ Other	
7.				☐ Treatment ☐ Test ☐ Other	
8.				☐ Treatment ☐ Test ☐ Other	
9.				☐ Treatment ☐ Test ☐ Other	
10.				☐ Treatment ☐ Test ☐ Other	

Code of Alabama 1975, Section 25-5-77(f), the employer shall pay mileage costs to and from medical and rehabilitation providers at the same rate as provided by law for official state travel.

MILEAGE REIMBURSEMENT SUMMARY

A.	Total Round Trip Miles	$ _____
B.	Approved Mileage Rate Per Mile	$ 0.76 (76¢ per mile)
C.	Total Reimbursement Requested	$ _____

EMPLOYEE CERTIFICATION

I certify that the information provided above is true and correct and that these expenses were incurred as a result of treatment for my compensable injury. I have not been reimbursed for these expenses from any other source.

Employee Signature: _____ Date: _____

FOR OFFICE USE ONLY

Date Received:	Claim Number:	Amount Approved: $ _____
Reviewed By:	Check Number:	Date Paid:
Comments:		Initials: