STATE OF WEST VIRGINIA
STATE AGENCY
WORKERS' COMPENSATION PROGRAM

Send Completed Form To:
Zurich Insurance
PO Box 66941
Chicago, IL 60666-0941
FAX: 847-240-8172

Claimant Travel Voucher

TRAVEL VOUCHERS MUST BE FILED WITHIN SIX MONTHS OF DATE OF TRAVEL

1. Claimant's Name (First, Middle, Last)		2. Claimant's Address (Street or P.O. Box, City, State, Zip)
3. Claimant's Social Security Number **last four digits**	4. Date of Injury	5. Claim Number
6. Provider's Name (please print)		
7. Address of Point of Departure (need physical address or closest route number)		8. Address of Point of Destination
9. Time of Departure ☐ a.m. ☐ p.m.	10. Time of Return ☐ a.m. ☐ p.m.	11. Purpose of Travel

Medical procedure codes to be used below in column 14:

Code	Description	Code	Description	Code	Description
X0910	Hotel/Motel	X9910	Mileage (Occupational Pneumoconiosis)	X0930	Air Travel
X0915	*Meals	X0920	Mileage	X0935	Bus/Train
X9911	*Meals (Occupational Pneumoconiosis)	X0925	Parking/Tolls	X0300	Voc. Rehab (mileage for retraining)
X0922	Reimbursement for IME travel	X0921	Claimant travel 2nd physician same day mileage	FEDTR	Federal Black Lung - Travel

Hotel/Motel stay and Air/Bus/Train travel require prior authorization. Receipts must be attached when seeking reimbursement for all services other than mileage.
*Meals are reimbursed for authorized OVERNIGHT travel only.

12. Date	13. Procedure Code	14. Description	15. Units/Quantity	16. Changes

17. Service Provider's Signature	**18. Claimant's Signature**	**Date**	**19. Total Charges** $

The present employer is to complete the section below only if the claimant has lost wages in order to appear for a medical examination requested by Zurich Insurance. (Not for routine medical treatment).

EMPLOYER FILL IN SECTION ONLY

20. Employer's Business Name, Address and Phone Number			
21. Date(s) of Lost Wages	22. Number Hours of Wages Lost	23. Hourly Wage X	24. Amount of Lost Wages = $
Date(s) of Lost Wages	Number Hours of Wages Lost	Hourly Wage X	Amount of Lost Wages = $
Employer's Signature	**Title**	**Date**	

INSTRUCTIONS FOR COMPLETING CLAIMANT TRAVEL VOUCHER

Each travel voucher can contain expenses for only ONE CLAIM and visits to ONLY ONE SERVICE PROVIDER.
If information is wrong, missing or illegible, the form will be returned to you.

1. **CLAIMANT'S NAME:** Your full name as it appears on the letters we send you.

2. **CLAIMANT'S ADDRESS:** Your full mailing address including zip code.

3. **CLAIMANT'S SOCIAL SECURITY NUMBER:** The last four digits of your Social Security Number.

4. **DATE OF INJURY:** In an occupational pneumoconiosis or disease claim, this is the date of last exposure.

5. **CLAIM NUMBER:** The number assigned to your claim by your workers' compensation carrier.

6. **PROVIDER'S NAME:** The service provider that you went to see.

7. **ADDRESS OF THE POINT OF DEPARTURE:** Your workers' compensation carrier reimburses for mileage from the claimant's residence. This street address must be written completely including street, city, state, and zip code. (No P.O. Boxes)

8. **ADDRESS OF POINT OF DESTINATION:** This is the complete address of the service provider's office to which you traveled. Include the street, city and zip code. (No P.O. Boxes)

9. **TIME OF DEPARTURE:** This is the time you left your residence (the address of the point of departure).

10. **TIME OF RETURN:** This is the time you returned to your residence.

11. **PURPOSE OF TRAVEL:** The reason you made the trip.

12. **DATE:** The date of the travel, meal, lodging etc. Put only one type of expense on each line.

13. **PROCEDURE CODE:** The code list is on the front of the form in the first shaded area. Find the code for the expense for which you are billing and put in this block.

14. **DESCRIPTION:** Explain the type of expense for which you are billing.

15. **UNITS:** The number of miles traveled.

16. **CHARGES:** The total charges for the line item.

17. **SERVICE PROVIDER'S SIGNATURE:** All vouchers must be signed by the service provider you went to see.

18. **CLAIMANT'S SIGNATURE AND DATE:** This is your signature and the date that you are sending this form to us.

19. **TOTAL CHARGES:** This is total of all the amounts in the "charges" column.

20. **EMPLOYER'S BUSINESS NAME, ADDRESS AND PHONE NUMBER:** This is the employer's information.

CLAIMANT: DO NOT FILL OUT BLOCKS 21 through 24. This section is completed by your current employer if you missed work and lost wages because you were attending a medical examination requested by your workers' compensation carrier.

After this form is completed, make a copy of the form and any receipts for your records and send or fax the form to Zurich Insurance at the address or number on the front of the form.

Meal reimbursement will be made only if the claimant has been authorized for overnight travel.
Lost wages will be reimbursed only when the claimant appears for a medical examination requested by your carrier.